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DEPARTMENT OF THE ARMY
Office of The Surgeon General
Washington, 25, DC

U.S Army Surgeon-General's Office

30 August 1948

SUBJECT: Report of Conference of Commanders of General Hospitals and Medical Centers

There is transmitted herewith for your information a copy of the report of the conference of commanders of general hospitals and medical centers held on 4-5 August 1948 at the Pentagon, Washington, D. C.

FOR THE SURGEON GENERAL:

T. J. HARTFORD
Colonel, M. C.
Executive Officer

1 Incl.
Report of Conference

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AUTH letter MEDCA 311.5
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SECURITY OFFICER
Frank B Rogers

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Representatives of General Hospitals and Medical
Centers Attending Conference Held on
4 - 5 August 1948

Major General George C. Beach, Army Medical Center, Washington, D. C.
Major General John M. Willis, Brooke Army Medical Center, Fort Sam Houston
Brig. General Paul H. Streit, Brooke General Hospital, BAMC, Fort Sam Houston
Brig. General Harry Offutt, Percy Jones General Hospital, Battle Creek
Colonel Asa Lehman, Army & Navy General Hospital, Hot Springs
Colonel George Reyer, Wm. Beaumont General Hospital, El Paso
Colonel Edwin A. Roberts, Fitzsimons General Hospital, Denver
Colonel Philip P. Green, Madigan General Hospital, Tacoma
Colonel John M. Welch, McCormack General Hospital, Pasadena
Colonel Harry A. Clark, Murphy General Hospital, Waltham
Colonel O. H. Stanley, Oliver General Hospital, Augusta
Colonel Kenneth Brewer, Valley Forge General Hospital, Phoenixville
Colonel Kermit Gates, Letterman General Hospital, San Francisco
Colonel David E. Liston, Fort Totten Army Medical Center, Fort Totten
Colonel Leroy D. Soper, Tilton General Hospital, Fort Dix
Colonel Arthur Redlands, Tilton General Hospital, Fort Dix.
Colonel James N. Williams, Sta. Hospital, Fort Bragg, N. C.

GENERAL BLISS:

Good morning, gentlemen. I think I have seen most of you personally. I am delighted to have you here and to greet you. I am sure you know why you are here, but I want to review for just a moment - it will be covered fully by members of my staff - why we are here and what we have to do. It comes down to personnel again and I will speak now principally of doctor personnel - the Medical Corps.

As you know, the draft bill passed without having anything in it to do with medical means. I want to give a brief summary of the history of that bill, which General Armstrong will cover fully. Defeat of the draft bill for medical officers was brought about because of the opposition at the time of the American Medical Association. They advanced three reasons for the opposition: One, they did not believe doctors, as such, should be drafted any more than engineers, lawyers, or other professional classes, which seems to be perfectly reasonable. The second reason they had for opposing the drafting of doctors was that the Army perhaps did not know how many doctors they required and that the stated requirements were too high. This is subject to critical survey, if anyone wants to be critically, survey it. We have been studying our requirements since 1775, particularly during the last year and very critically during the last six months. Our requirements have been reviewed from every angle, particularly from experience tables. In comparing our experience with Tables of Organization, I can state, roughly, that if we need 100 doctors today we have 80. Our requirements, if we state them as 100, may be open to argument to a certain extent but without any question we certainly need 80% of our computed requirements for the present size Army. If we completely controlled our means and used them with the utmost intelligence we might be able to provide proper medical care with the 80% for a reasonable length of time. However, any form of critical survey will show we cannot get along and give the treatment we are supposed to give, and the total medical care and service we are supposed to give with 80% of the doctors we claim we need now if the Army is increased in size. The third reason was that it was not necessary to draft doctors because they would volunteer in the numbers needed. The American Medical Association has accepted responsibility for the non-drafting of doctors and they have further accepted the responsibility of endeavoring in every manner of getting the doctors we need in the numbers we need. If that does not succeed, the AMA has further agreed to support and sponsor a draft bill for doctors. We are working in close association and complete cooperation with the leaders in American medicine.

The lack of doctors at the present time, where we have 80 instead of 100, confronts us with a serious problem. It imposes a challenge on us, one which we have to meet by using the medical means available to us to the best advantage. It is for that reason that we have just had a conference of all of the Army Surgeons and Air Surgeons and have asked you hospital commanders in here now to talk over and have these problems presented to you.

I think when we state we will keep up the standards we have established (and we have no intention of deviating from them) our computed requirements are perfectly sound. We have no intention of cutting down or curbing the training program whatsoever. We believe it should be expanded rather than curtailed. I hope you will all think of that. We believe that part of our program, professional training, is one of the real postwar accomplishments, and to curtail or stop it would be sheer stupidity, to use General Armstrong's term. I think it would be a very poor thing to do.

It is the simple way to say that we will save doctors by not taking care of patients. That is also a shortsighted policy as far as I am concerned.. In relation to that is the care of dependents. We must continue this care because of the moral responsibility. It is always stressed in recruiting programs. It has always been done, and is expected of us. In salaries paid to service personnel it is expected and is a part of a salary. I don't want to see any cutting down on their care. That is an overall statement and I could qualify it by saying we must furnish the care which is medically necessary but not necessarily all the attention which may be demanded.

A number of people have suggested that we should not take veterans. Most of the veterans we are caring for are in our teaching hospitals, are receiving specialized treatment in hospitals near their homes which are otherwise unavailable. This specialized care is not only deeply appreciated by the veterans themselves but the teaching incident to it is invaluable in our resident training program. I think we should not attempt elimination of this type of veteran patient. It presents a serious problem. Doctors are required to take care of them - whether in our hospitals or others. All of the details of this will be covered by speakers coming on later.

I have just returned from Germany and have been very much impressed with the care and quality of the medical services being rendered by our Medical Department. All of us can be proud of this service in all of its phases, not only in the curative care rendered but in the administrative medical work by the hospital commanders and in the field of preventive medicine. The sick rate is as low as it has ever been. The patients are as few as they have ever had. It is interesting to note in the professional curative program some 76 consultants have gone over there. Every month we have three or more consultants, who represent a cross-section of the best in medicine, visiting Europe. They spend two or three days each in our 15 hospitals. Our top Regular Army men there in professional medicine are few in number. Most of the doctors are ASTP graduates and these young men are interested, able, and doing excellent work. These visits by the consultants very definitely stimulate these young men. The consultants make rounds with them, perform operations, have clinics, etc. These visits assure us that we are keeping up with the highest standards in this curative medicine field. When the consultants come home (they have seen the excellent work being done and are very much impressed) they are asked by the families how conditions are, how their boys are being cared for

The families who talk to these doctors believe what the doctor tells them and the doctors having seen, believe what they are saying - because it is true. These top men come back and go to medical society meetings and talk about their visit - I am astonished how they travel around - they are at the meetings, are questioned by their colleagues, tell what they have seen and how impressed they are with Army medicine. All of this helps the Army Medical Corps and this help and goodwill is cumulative.

We now have a challenge to meet. We have generally met our challenges, and we expect to meet them now. We need to conserve our medical personnel and that means the most intelligent use of our personnel. That's what we hope to accomplish. We must prove to American medicine and to ourselves that we are making every effort to make the best and most intelligent use of our medical means. I sincerely hope and believe that this conference will be mutually beneficial.

GENERAL ARMSTRONG:

The purpose of my brief remarks will be to go over the events of the past few weeks in order that you may know how we have been thinking and worrying, and in order that you may share properly with us your appropriate part of this worry. I would like to go back in my orientation to the events which occurred immediately after the war. I would like to remind you particularly of the questionnaires sent out to several thousands of doctors, who served in the armed forces, by The American Medical Association, and the assembling of the facts brought out by those questionnaires, in which the Medical Service of the armed forces was not painted in a very favorable light. Perhaps the two biggest causes of dissatisfaction among those individuals serving with us were (1) non-use, and (2) miss-use. In other words, people were left sitting around in training centers for months, not doing anything, and also the matter of being assigned a job for which the individual was in no wise qualified. Immediately after we had shaken down after the war, this office began figuring out ways and means of avoiding those mistakes again, both in peacetime and in the event of another major mobilization. With all that have come some radical changes in personnel thinking and actions. Career guidance is no longer an idle dream. Talk with Fred Fielding and let him show you, if you are not familiar with how it works, the method of properly classifying every individual going into this career pattern. In case of reserve units we propose echelonment of personnel, as actually needed, rather than bringing whole units on and leaving them in Camp Bowie or some other post for a year or more before being utilized. The IG, together with the SG, has reviewed all of our installations world wide and reports today there are very few medical officers occupying spots that should be occupied by other than MD.'s. So, we have not been standing still for the past two years, and for the past several months we have been going over Tables of Organization, over our allotments to those not mentioned by the TO, and cutting down, not with the idea of trying to

reduce any ratio to a lower fraction, but to get our personnel requirements in the lowest possible terms and still render the kind of service The Surgeon General thinks we should render. All this was going on before the President asked Congress last March for three things: the ERP, Universal Military Training and Selective Service. I recall how everyone left the radio where we had been listening to the President and there were no comments, either serious or facetious, and everyone returned to their respective offices knowing we had a big problem ahead in the Medical Department. Someone remarked, "It never occurs by lysis, always by crisis." So, we started to work. General Bliss insisted that we have prepared, regardless of what turned up in the way of Selective Service or military training, a piece of legislation to assist us in the event we needed medical and dental personnel. We were not in on the early phases of the draft legislation, for, as usual, it was not coordinated with us, and it was only by chance that our Chief of Personnel was able to see the draft of this bill as it was going over to the Hill. I will not dwell on the dissactisfaction that the first draft of this legislation created, particularly in the medical profession. The first time we really knew how AMA felt about it was when Colonel Robinson happened to be invited to a session in Mr. Gurney's office and there were present representatives of the AMA; and there they agreed on certain priorities: (1) Those who had participated in government financed schooling and had not served on active duty upon completion, (2) Those deferred but who had not participated in government financed schooling, and (3) those who had served least. Some changes had to be made, such as not disturbing men who had been "dug in" in their communities. From that meeting Colonel Robinson returned feeling the Medical portion of the Selective Service bill would not be terrifically opposed. In the meantime, we had not been remiss. Unless some relief was obtained, we stated repeatedly that we would be unable to support the draft from a medical standpoint, and on the afternoon of 18 June of this year when we learned they had deleted the medical-dental section from the law I was asked why I was not doing anything. I called General Persons, and they said there was nothing more to do. They stated they had met with General Bradley and Mr. Royal, only that morning, and that all thoroughly understood the implications. They believed there would be some relief, even if in an A T T E N U A T E D form. I left that afternoon for Chicago thinking surely there would be some relief, and when I learned the following day that the entire section had been deleted, you can imagine my feelings. It was during the week in Chicago that I first learned of the opposition organized medicine had put up. At the same time we learned that those individuals responsible for that deletion had not intended, nor did they know, that the portion of the bill was deleted was the one which would have required ASTP's and V-12's, and those others who had never given any active service to be brought into the Armed Forces. When we recovered from the shock of this situation we began grasping for ways and means to do what we could with what we had to meet the crisis, knowing full well - and I think this was not a defeatist attitude as anyone looking at the charts with Colonel Robinson will show you can see, that we could not meet it, and knowing The Surgeon General would

eventually have to go before Congress and defend this situation. We felt it was up to us to come up with every possible saving, and assure Congress and the public that we were properly utilizing and conserving the means at hand. We were called before the Board of Trustees of the AMA during the week of 21 June and asked to discuss our requirements and we refused to give any ratio, 6.5, 5.5 or anything below that, insisting that what we are trying to do is utilize the smallest number of personnel possible, knowing there is a nation-wide shortage of this commodity, and that after you have reached rock bottom it is immaterial if you want to turn it into a ratio. I think I can say that in general that attitude met with favorable response on the part of the AMA. I also knew we could not just talk and not act, when we returned to the office on the morning of 28 June we carried to G-1 and the Chief of Staff papers in which we set forth what we thought we could do and some of the things we proposed to ask for. At that time, not knowing the exact plans of the General Staff, we made this blanket statement which later was turned back at us. We said at that time that without more relief than we could see without legislation, and taking cognizance of every means by which we are going to try to conserve personnel, we could support the expansion only until the end of the year, providing the expansion took place in current facilities and current installations and that we could not undertake to open one single new post. We later modified that, as I will come to in a moment. During the first few days after 28 June we had literally scores of suggestions as to how to conserve personnel. Many were sound, many crackpot, so I created a group, later known as the Harford Board, to go over these suggestions and determine which seemed sound and which we should explore. About that time we began thinking of bringing in representatives from the field. The reason we did not bring you in sooner was that we felt the boys getting the impact first would be the Army surgeons and Air Command surgeons, and so we sat a date for that meeting. We gave them time to think over the problems, set a date for the 13th and 14th of July, and, fortunately, it was during that meeting we first learned definite plans regarding expansion on the part of the General Staff, so we were able to sit down and go over area by area, post by post, and in the meantime learned that actual induction of the men was to be postponed two months. So finally, on 15 July, we went to the General Staff again, and this time we said, "Now knowing your plans and now having conferred with our Army surgeons and Air Command surgeons, we modify our previous statements, and it is our opinion we can medically support expansion as planned by the General Staff up to and including 28 February 1949, and from then on we can support that strength, provided there is no further expansion, through March and April, and then we can no longer give any standard, even minimal, of medical service." As you know, beginning in May and running through June and July we lost 2100 medical officers. At first glance this seemed to be decidedly a more optimistic view than on 28 June, but actually it is not so optimistic, and when presented to General Bradley he saw it was not an optimistic picture. The seriousness of this situation has been such that the utmost consideration has been given by everyone in Washington regarding further legislation as a means of

relief. There was drawn up what we believe is the most noncontroversial bill possible. It includes only the drafting of those individuals who were deferred to pursue a professional course of instruction, whether participating in a government financed program or not. It must have the official support of the AMA. They have met with us on two occasions and are in agreement regarding the wording of this law, and their final full support of it depends on something being considered by the Secretary of Defense, some sort of an advisory committee at the Secretary of Defense level. That is a very reasonable request on the part of civilian medicine. In the event of any expansion or mobilization we are entirely dependent on civilian support and our Medical Service becomes very predominantly civilian, and it is only reasonable that civilian medicine have a say in the overall policies, at least in advice regarding them. It is expected that we will know in a matter of hours whether such an advisory committee or counsel will come into being. The next question is whether we can get this before this Special Session of Congress. At the moment the outlook is very dim. In spite of the fact that I saw a statement just before I came to this meeting to the effect that at one General Staff conference it was decided not to offer any piece of legislation except the bill of which I have just spoken, it is still very questionable whether such a thing will even be submitted. There are pretty good reasons why they do not want it. There is considerable dissatisfaction with a peacetime draft and that would be particularly true if we had news of a break in the Berlin impasse. I think if we got word that the Berlin blockade had been suddenly lifted, it would endanger the very life of the Selective Service Act of 1948 and anything pertaining to it. It would create the possibility of getting amendments which might nullify it to the point where it would be a useless instrument in the building up of our national defense. It is my opinion no action will be taken by this Congress to give us medical relief. Coming to the opening of a new Congress in 1949, again we are going to have difficulty in getting any speedy action. You say, what about doctors and the people in organized medicine? We have discussed this with the AMA, and frankly, they are no more optimistic than we. We are giving credit for 200 volunteers that will come in as a result of moral suasion! We are going into 1949 with a picture no brighter than today. We are afraid that even if we get the necessary legislation we will not have one single additional person in uniform before July. It takes time to get laws and then implement them. So, when a person like Dr. Don Pillsbury says the Medical Department is facing the worst crisis in 25 years, I think he is being very conservative in his statement. We brought you in here primarily to impress upon you the seriousness of the situation, to impress upon you the fact that this medical situation actually may interfere tremendously with our national security. Furthermore, when things do get worse, you will know what we are trying to do, and that is to preserve the national security as much as we can and still do our job. It is also hoped that the tour here may enable the hospitals to get in some changes that have been bothering us for some time, and for that reason we have brought in Colonel Clark, Colonel Stanley, and Colonel Morgan for recommendations as to revising some of our antique procedures which are turning some of our hospitals into hotels! You are here not to be given the

answers but to help us work for at least a partial answer. I want you to feel it is your meeting as well as ours, and be ready to come up with even the most minor suggestions to help us in our goal to render satisfactory medical service in the hope that we will not limit the expansion of the armed forces.

COLONEL ROBINSON:-Medical Dep't. Personnel and expansion of the Army.

I will follow up General Armstrong's preliminary remarks. What I propose to do is to set down the facts as we now see them with regard to personnel and then to outline in some detail our plan for attempting to remedy the situation. You will notice on the agenda that Colonel Epperly, Colonel Maley, Colonel Goriup, Colonel Vogel and Major Manner will speak for very brief periods on the personnel they represent:-the Dental Corps, Nurse Corps, Medical Service Corps, Women's Specialist Corps and Enlisted Personnel. We have left the Veterinary Corps out because we felt their problem in general hospitals is not so acute that it needs representation here. This is with the concurrence of the Chief of the Veterinary Division. Apropos of tomorrow, I have been kidded about this, saying we are going to solve the whole thing in thirty minutes! The session tomorrow is for the purpose of effecting mutual readjustments that have to be made to equalize the Medical Service throughout. We did this same thing with the Army surgeons and Air Command surgeons and felt it extremely beneficial. We have 4,350 doctors now and we actually need 5500.

(At this point Colonel Robinson gave a graphic description of information contained on charts pertaining to the Medical, Dental, ANC, MSC, WMSC, and enlisted personnel.)

Now, I would like to come back to the general hospitals again. I don't know whether or not this booklet covering the Army surgeons' conference was delivered to you, but there are a few things in it I would like to point out. One of the officers said, "It is just impossible to make an American Board man out of everybody that is going to be in the Armed Forces. I think it is anyway, and I think it is unnecessary, whether it is impossible or not." Another: "The Air Force has 796 total in the United States, I mean World-Wide, 614 of which are on duty with troops within the United States. That means that 514 doctors are giving the field medical care for 247,183 as stated on this paper, or one doctor for every 481. There are available 4350 doctors, I don't know how many the Army has overseas, I can't account for where all of these doctors are. I'm just trying to figure it out in my own mind here. It looks like there might be a little maldistribution. I'm wondering if the General Hospitals are perhaps staffed to the point where the people who are actually cutting the mustard with troops, where military medical men are supposed to be, I wonder if they are doing that at the expense of the proficiency of the Medical Service to our soldiers. Personally I am convinced that military medicine and the preventive aspect of military medicine are part of our primary duties,

that we should advertise them more, we should think in our own minds that they are more important, and to think in our own minds that we are important that we are engaged in it. And we certainly should convince organized American medicine to some degree that preventive aspects of military medicine are as honorable, and as valuable, and as necessary as any other higher degree of specialization. I wonder if there is anyone that has any similar ideas of that kind." Another, "I do believe that we have failed in trying to get people, we have placed too much emphasis on the high specialization that we are trying to offer people. And I doubt very much if we can produce. I think that we should appeal more to the general practice people and try to get their interest in this program." Another, "If we want to encourage men and open opportunities to men in a field of military preventive medicine, let's then turn the pages back to the station level and build up our hospitalization program there in the midst of their patients, in the midst of their military dependents. Let's give them the type of service many of us can remember. The kind we did at station level 10 years ago before the war and considered it a very creditable type of professional service. I'd say we have a product to sell but we should sell it where the men will come in contact with the Army and the Air Force." Another, "Suppose everyone in the Medical Corps becomes a Specialist. Are they going to stay in the Army? I can see, if I were a young man coming into the Service, and I was advised to report to Meade or some dull station where I had nothing to do but look after a few colds, I think I'd resign. I think we have gone too far in trying to sell the specialty, even though it is very important. I am inclined to believe you should go in and try to sell military medicine." Another,"And I think that we should come back and establish some of our old ideas and principles and insist on following the thing through in that line. If we don't, we are going to continue with this same situation we have today. The function of medical officers at the bed side, we don't minimize its importance, is only one of our functions, and I certainly think that all of us agree that the prevention, keeping that man out of that bed and from being a loss to the Army, is certainly at least as important as treating him after he is no longer an asset to the Service." Another, "There are some problems that have to be met, by laying your cards on the table. Colonel Ogle mentioned about the General Hospitals being over-staffed. I think they are. They have a big training problem and they have been doing a grand job. But as a matter of comparison, I have a list from Letterman GH. I counted the MC's on duty there. As of the 15th of June, they had 127 which include their interns, and as of that same date I had 107 for the 6th Army Area."

I read those excerpts merely to show the fact that the way we are carrying on this training program is not fully in accord with the ideas of all of our medical officers. I would like to say this, however; that for two years a valient effort was made by the Army and the Medical Corps to get doctors on the basis of selling on military medicine and practice as we knew it before. We failed badly. We are convinced, after very careful study, that the only possibility of filling the Regular Corps in anything like a reasonable length of time is to pursue a course somewhat as we have started, that is a medical training program in conjunction

with procurement, using civilian hospitals for those we cannot take into our own program. I want to expand our service, open Valley Forge not later than next July, and take 100 residents and 50 interns. We could do it if we could start now. I think that more or less sets the background, and I would like to go over very briefly what the plan is for both long range and short range personnel problems. The first thing in the long range program is to fill the Regular Army Medical Corps. We feel quite sure from the response we have had to date on our Procurement-Training Program that we can fill the Regular Army Medical Corps in two years. The one question that stands out in our minds is whether we can hold them. We have to do something to change the situation so that doctors will want to stay in the service. I don't think it is within our power to bring on a depression, which might be the best way to do it! We have analysis information in the past year as to why doctors don't want to be in the service and I would like to go into this very briefly. One of the primary reasons was lack of adequate training programs and facilities. I think we have gone a long way in the last two years in correcting that. We do have a training program, one that civilian educators believe is among the best in the country. We have had some name us as among the top ten. As I say, we think that complaint is being corrected. However, we don't have enough facilities for the number we need to train to meet the Army Procurement Program. The second reason given was the lack of respectable housing, and this is really a tremendous problem. Doctors in civilian life do not have to subject their families to inferior living conditions. Of course, one can say this applies to the Army as a whole. It does without doubt, but on the other hand the Army hasn't had the same trouble in the procurement of Army officers as we have had in procurement of medical officers, and we should like to convince our staff that we should do something on this point. Another thing is that moves are too frequent. Our policy is the same as the Army, a 3 to 4 year tour of duty, but when three-fourths are on duty for only 24 months it is impossible to maintain the 3 to 4 year move policy. Undesirable assignments, overseas and dispensaries, it is not possible to change. However, we should try to make them more attractive. Most frequently mentioned is the attitude of line officers in making servants of doctors, particularly true in the Air Force, but not absent in the Army. Our doctors must be taught how to combat those things. I heard a doctor say an Air Force officer called him and told him to bring him a dose of sulfamerazine. He was not a patient. The doctor was ordered to do it and when he refused he was called before the commanding officer and reprimanded. Our doctors have to be taught to handle a situation of that sort. Regarding lack of medical control over personnel, it is probable The Surgeon General will get more control over facilities. There is to be an experiment in the Third Army Area, and may re-establish technical channels. A very prominent complaint from the younger officers is that they have inadequate support and guidance from our senior officers. We know of instances where this has been true without any question. In general, I hope it is not true, but if it is it would seem to us, a result of the fact that during pre-war days adequate training was not given to our officers

so that they could render the necessary guidance to the younger officers. We have initiated a public relations program within the Corps itself, which I hope some of you will read about from time to time in the Bulletin and other publications, in an effort to improve this condition by informing our officers of things that are going on. Inadequate pay is always a thing that comes up with everybody. I think I should pause here and say the Army itself, the Defense Establishment, has been making a study of pay for most of the past year. It was first made by the military and a proposed table and law were written up with substantial increases in pay for all officers in the service. That report was referred to a civilian committee, the Hook Committee, which has been working on it for almost six months. It's method of working was this: Certain jobs were selected and a complete job description was written. I think Letterman and some of the others helped us, producing their job descriptions for that committee. Then, they compared those jobs with similar ones in civilian life and have come up now with a new pay schedule. Actually, considering it in terms of dollars which the medical and dental officers get, there is a reduction in pay on the table the Hook Committee has proposed for Lieutenants, Captains, and Majors with a certain number of years of service, and I understand their reasoning is that the younger doctors in civilian life do not make as much as Army doctors. I believe in some instances that is true. In the higher grades there is somewhat of a raise in pay. The Hook Committee originally recommended that the $100.00 under Public Law 365, 80th Congress, be done away with, but representations have been made to the Hook Committee. It is our understanding they are now going to recommend that the 5 year law stay in effect as it is. Whether we should make a study of pay ourselves is a matter we have under consideration now. Ideas from this group would be helpful. The complaint of the failure of government to provide security has not arisen very often, but it is said the security of an Army doctor does not compare with that of a civilian doctor. Another complaint is too many non-medical duties. A campaign has been on for two years regarding this, and it is believed the matter is now well under control. There are very few doctors anywhere now doing duties outside of medical duties proper. No assurance that assignments will be the same as training is another complaint. You are all aware of our assignment problems. However, in the current "Bulletin" our complete career planning scheme is written up. I hope you will encourage the younger officers to read it. Actually, doctors are sent to all commands now under requisitions for specific specialties and qualifications, and, as far as possible, we are doing it that way. We think this program can be continued and we think it will eventually be effective, but it will take many years to prove the system. In holding our Regular Army officers we have to do everything we can to correct these discrepancies, if they are discrepancies. We must commission only the highest type. We have to increase the respect of the Corps by training our doctors to the stage where they can take their place anywhere in medical circles all over the world. There are a number of suggestions which have been mentioned in the long range procurement of doctors. One is subsidy of undergraduate education. Three plans are now in formulation on this subject.

Public Health has a bill sponsoring the subsidizing of undergraduates and links with grants for medical colleges. The Gray bill links with R.O.T.C. The Committee on Medical and Hospital Services of the Armed Forces has considered a bill which will be a medically controlled bill for the subsidy of medical and dental education. We don't know the outcome of that. Another thing which has been suggested is the establishment of an Army medical school. It is estimated that the initial cost will be $50,000,000. Some difficulties encountered would be the obtaining of clinic indigent patients and another the obtaining of a faculty. No one can tell what will happen, but the thinging, as far as the office is concerned, is that the majority are against the establishment of a medical school. A number of us, however, are for it. We think our contacts with schools should be continued through R.O.T.C. and P.M.S.&T. We think we have done a good job with these. Colonel Duke can give you figures with regard to interns and other contacts which make us feel it has been beneficial. The short range plan is to set interim standards for medical care, to continue the procurement training program, work with AMA in obtaining volunteers, utilize all of the civilian physicians we can and investigate use of government hospitals, endeavor to arrange so commissioning can be accomplished rapidly and the doctors placed on duty as soon as possible after they become available, and finally, we will try to get Congress to pass some draft legislation.

COLONEL WALSH OF PLANS DIVISION:

The troop basis for general reserves has been approved and published by the General Staff. The phasing plan for that troop basis, extending from October to June 1949, has also been approved. Some units will be phased in 1950. The majority will be under the command of The Surgeon General and located in Class II installations. We have prepared actions that are going to be taken with regard to service type medical departments that will be located at Class II installations. It will be given to the Class II Commanders so they can do a little future planning by knowing in advance what is contemplated in the line of activation, reorganization and movement of these units. The routine procedure to be followed will be for The Surgeon General to request that action letters be issued by The Adjutant General effecting all actions outlined in this paper. The action letter will be addressed to The Surgeon General, as in the past, and then indorsed over to the Class II Commander for compliance so that the Class II installation will issue all necessary orders to effect the action that will be outlined in The Adjutant General's letter. We have specified on the third page clarification of terms to be used as related to the locations specified and Class II installation.

COLONEL EPPERLY:- Dental Personnel.

The situation regarding the dental personnel in the Army hasn't changed materially since the last time you were in at a conference with The Surgeon General; so little in fact that we are still using the

same charts you saw at that time. This can be interpreted as meaning that gains from procurement have about accommodated losses due to separations and retirements. You have heard Colonel Robinson speak of the influence the shortage of medical personnel has upon the expansion of the Army, and I might say to begin with, that it is a good thing that life and death or the expansion of the Army do not depend on dental treatment, as I am sure we have been unable to satisfactorily care for military personnel in this respect for some time.

You have been shown a chart which shows the losses of Dental Corps personnel over a period of three years - at the end of which time the total number of dental officers on duty with the Army will be down to 550. The chart I have here is a little more specific, and in reality shows that our big losses are occurring during the months of July, August and September of this year, and that the total strength of the Dental Corps will be down to that figure by the end of 1948. You can also see from the chart that volunteer Dental Corps officers on duty with the Army are remaining fairly constant, and procurement under Circular 51 for officers of the Regular Army has about taken care of the losses which we have suffered from retirements.

In 1947 there was a shortage of about 33% of our requirements in dental officers, at which time we were able to render about 62% of the dental treatment indicated. By the time that all of the non-volunteers (Category V) are separated and the expansion of the Army hits its peak in 1949, it can be seen from the chart that only 9% of the dental treatment indicated can be taken care of. This is believed to be a very conservative figure, as it is during such periods when definitive treatment must be deferred in favor of emergency treatment, and it is at such times that the emergency treatment gets very voluminous due to the Definitive treatment being neglected. The time is very nearly here when, not giving any consideration to any expansion of the Army, we will be able to accomplish only 20% of the dental treatment in the Army which should receive care.

COLONEL REYER:

What is going to be the policy on dependents when you get down to where you can only do 9% of the dental Treatment, are you going to discontinue it at the places now doing it? We are still trying to.

COLONEL EPPERLY:

We have received informal information to the effect that the treatment for dependents has already been discontinued or curtailed, and The Surgeon General has forwarded to the Staff, for their concurrence, a proposed publication of a Department of the Army directive which will restrict the dental treatment for dependents to emergency

care only. I might say that this request has just left the Office of The Surgeon General and whether it will meet with favorable consideration in the General Staff is unknown. As you know, the regulation covering this subject reads that "dental treatment to dependents will be rendered when practicable," and leaves such decisions entirely in the hands of the local people concerned.

GENERAL OFFUTT:

How is that going to effect your recruiting program? Is this not going to have the same effect on the overall recruiting as refusing to give medical treatment would?

COLONEL EPPERLY:

There is no question about that - I am sure that we all feel that it will definitely influence individuals who are giving consideration to entering the service. We will, and always have, received plenty of complaints from all sources regarding dental treatment to dependents. We have always operated on a basis of 2 dentists per 1000 military personnel and 3 for trainees, and our requirements as we speak of it in this respect, are certainly austere in nature. The figures that I have shown you on the chart do not give any consideration to dependents and you could see that we were not even able to take care of all the treatment indicated for military personnel.

We were asked not long ago about some factors which were influential in the morale of our officers which were peculiar to the operations of the Dental Corps, and one of the first that was mentioned was the fact that in spite of any endeavors that might be made to finish the job, there was always so much left to be done that it was totally impossible to accomplish it all. I think it must be understood that even in the event we are fully up to our requirements on the basis of 2 per 1000, that all the dental treatment indicated for Army personnel and dependents cannot be accomplished, and that is definitely a morale factor within the Army.

Some consideration has been given to having the dental treatment which the Army is unable to do put on a contractual basis from civilian sources, but in such consideration it was found that the cost, figured in terms of Veterans Administration prices, exceeded The Surgeon General's entire budget by quite a bit. For this reason, and other objections to such a practice, this plan is not favored by many members in the Office of The Surgeon General.

I will take just a minute and briefly relate to you what has happened in the way of procurement and separations among Dental Corps officers. During the year 1948, 142 applications for the Regular Army have been received under the provisions of Circular 51. Of this number, 76 were in the senior grades (Major, Lt. Colonels, and Colonels),

and 66 in the company grades. Of this number, 19 have received favorable consideration in the Office of The Surgeon General - 16 of which were in the grade of captain or first lieutenant; 2 majors, and 1 Lt. Colonel. I might state here that the Dental Corps has about reached the saturation point in respect to the senior grades, practically all of them are filled now. Actually, we are 17 over our authorized allowance in the grade of major, but there are sufficient vacancies in the two higher grades to accommodate this overage. There remains 19 vacancies in the grade of captain, and out of an authorization of 267 in the grade of first lieutenant 252 are vacant. Procurement under Public Law 365 has not been too encouraging, and so far as applicants eligible for the first lieutenant grades have not applied in sufficient numbers.

New Reserve commissions: Since the class of 1948 graduated in June, 34 applications have been received from this group for Reserve commissions, all of which were granted. Of this number, 27 requested and were ordered to active duty; 36 requests have been received from Reserve officers who were formerly on active duty for further active duty and all of this group were given assignments. This brings the total to 63 of the group of volunteers whom we have on active duty since the beginning of 1948.

The internship program which was conducted during the year of 1947-48 was concluded on the first of July, and the results of this training, insofar as procurement is concerned, is not gratifying. Previous to the war most of our dental interns were desirous of a commission in the Regular Army, and we considered this a source of our very best officers. Of the 25 who were in training during the 1947-48 period information has been received informally that only 9 are interested in the Regular Army; 11 have requested further duty on a temporary basis and 3 did not desire further duty with the Army. It was thought that the people in the general hospitals could convince these young officers that a career in the Army was not so bad! This year the authorization for interns was increased to 50, of which number we were only able to fill 32. Two additional hospitals have been opened for this training, and it is hoped that the program will be more successful in gaining Regular Army officer material.

Steps which might be taken to provide more efficient utilization of the Dental Corps officers available are not too numerous. I think we all realize that when an officer is assigned duties away from his chair or office, that his professional activities are reduced in the same ratio as such duties are assigned him. I doubt whether this is happening in many instances, but in the cases where it is occurring it must be curtailed.

There are presently 19 officers assigned to ROTC units, each of which is receiving training in one of the specialized branches of dentistry. This may be regarded by some as an exhorbitant expenditure of dental personnel for the returns which might be expected, but in the years previous to the war these officers created a great deal of

interest in the Army and it is expected that this will occur again and that the procurement from this source will justify such assignments. In addition to the procurement factor in the assignment of these officers, they are all receiving such professional training as the institutions to which they are assigned have to offer, and since this is about the limit to which our training program extends, it would not seem beneficial to terminate this program and reassign the officers where they could perhaps accomplish the much needed dental treatment.

I think the provisions have been related to you of the plan to bring 150 doctors or dentists on duty with the Army on a Civil Service status. In accordance with the regular hours that have to be maintained in Civil Service operation, this appears to be very ideal for the procurement of some dentists at certain stations and hospitals. Since most of the dental clinics operate on certain scheduled hours and usually in conformity with those of the Civil Service, it appears a little more suitable for dental rather than medical personnel.

Some consideration is being given to the commissioning of students in dental schools below the graduate level. They would be commissioned as second lieutenants, Medical Service Corps, and placed on duty at the school with all pay and allowances until graduation, at which time they would be expected to serve a like amount of active duty with the Army. There are certain criticisms to such a plan - such as the interference that might be expected with the ROTC training program and others, and since nothing could be gained from such a practice for at least a year, it is not gaining favor from many sources. There are some who have confidence in the procurement of a few dental officers as a result of the recent Selective Service legislation. It is believed that there must be a group of approximately 2500 or 3000 who are between the ages of 19 and 26; however, the marriage and dependents clause of the legislation will have to be obviated or not very many officers will become available by this means.

You have heard what has gone on between the American Medical Association and The Surgeon General's Office with respect to such assistance as they might give in helping this situation. General Paul has queried the Office of The Surgeon General as to what organized dentistry intended to do, and I might state here that a conference is scheduled with a representative group of the American Dental Association in this office in the very near future. The problems confronting us will be presented to this group at that time - what assistance they might be able to give is strictly problematical. I don't think anyone is too optimistic in this respect.

You have heard Colonel Robinson say that one of the big objections of Medical Corps officers to service with the Army was the interference commonly met from people other than medical. The American Dental Association has reams of correspondence from dental officers who served during the last war with the same criticisms, but they commonly state that the interference comes from the Medical Corps. I am sure this

problem will be discussed during the conference.

General Smith, General Love and myself will be in the Dental Division during the days you are in town and if there are any individual problems or anything of a dental nature which you wish to discuss with any of us we will be happy to have you do so.

COLONEL MAIEY:- Nurse Personnel.

General Armstrong and Commanding Officers. In spite of the fact that we are doing fairly well with our present procurement, the Nurse Personnel picture is not a pleasant one. The Army Nurse Corps is fully aware that the situation is critical and that, with the future expansion facing us, we will have to make preparations to run our general hospitals with fewer military nurses, supplemented the best way possible with civilians. In order to give you a brief outline of the problems we are facing, it is necessary to give you an overall picture of the Army Nurse Corps in figures.

We have on active duty as of the 1st of August - 4,282 nurses; of that number 1,466 are Regular Army and 2,816 are members of the Organized Reserve. Our requirements to meet our present day needs, not including expansion, are 5,600; leaving us a shortage of 1,318 as of today. Since January 1948 we have lost approximately 1,100 nurses and have gained only about 600. The reasons for the losses I will give you only briefly: We lost 450 nurses by the expiration of category; we lost 450 AUS officers who did not apply for the Reserve Corps. These are the largest figures. We have lost a great many in the last two or three months for reasons of marriage and declining overseas assignments. Since last July we have lost 100 Regular Army nurses, most of these married or retired.

In March we launched an extensive procurement program. Nurses who served in the Army Nurse Corps during the War were contacted by letter which included information concerning the privileges, benefits, and facts about the Reserve Corps. At this time we were fully aware that we would not reach the quota for integration in the Regular Army. Schools of nurses in the United States were contacted. Packets containing literature of the Reserve Corps were sent to Directors of Nursing Services, Placement and Counseling Services throughout the United States, giving information concerning needs of the Army Nurse Corps. From all of our procurement efforts we have commissioned only 7,421 nurses in the Reserve Corps. Of that number, 2,816 are on active duty, yet there are approximately 381,000 registered nurses in the United States. Of course we know that thousands of these are not eligible to join the Reserve Corps, but we should have more. We have approximately 300 nurses on duty with no prior military service who have joined the Reserve Corps. We will have 75 or more students in basic training this September. We can all agree that this is alarming from the figure of 62,000 nurses who served during World War II, only some 8,000 have joined the Reserve Corps. We do know that many are not

eligible by virtue of age, marriage, dependents, physical disability, etc. However, there must be something which needs immediate attention in the Army Nurse Corps to interest other nurses.

We know of many reasons why nurses are not interested in the Army Nurse Corps, and have made every effort to correct them but, until we have more nurses on duty, we will not be able to establish the personnel practices which we feel are so necessary to the welfare and happiness of the nurses.

Briefly, here are some of the reasons we think are keeping the nurses from coming on active duty: (1) Long hours of duty, - in the majority of our hospitals they are still doing 12-hour night duty. I know of no institution in civilian medicine where the general duty nurse works 12 hours either day or night; (2) Living conditions; (3) Undesirable assighments; (4) Personnel practices; (5) Promotion policy. We have to look for a moment to what civilian nurse organizations have done for their nurses. They have taken great steps and have made advancement in offering to the nurse social and economic security, improving personnel practices and policies within their hospitals and generally recognizing that the nurse of today certainly should be given the same rights and privileges of other professional groups. Nurses are no different than 143 million other people in the United States. They too are interested in shorter hours, better working conditions, recognition for the job they are doing, and most of all being considered as individuals. I sometimes wonder if we are making every effort to treat our nurses as individuals, to listen to them, to make them feel that they are an important part of our big organization, to do the things that make their working and living conditions as pleasant as possible, to make them happy in their jobs, because an individual who is not happy in his or her work does not do a good job.

We are still getting reports from nurses that being placed on night duty immediately upon reporting for duty in a hospital. This may once have been the policy used by chief nurses, but it should no longer exist in our hospitals. It does not take the word long to get out among other possible candidates for the Army Nurse Corps that a nurse was placed not only on duty the day or hour of arrival, but on night duty that night. They are not familiar with the ward routine, the patients, or the ward officers; consequently they have a grudge against the Army from the beginning.

In the last month we have actually had three reports from hospitals stating that this has happened to them. Positions in civilian nursing today are more plentiful. It is well known that nurses are a transient group, and they know positions are available to them in any part of the country for as long as they want. They also know that there will be a great possibility upon joining the Army Nurse Corps that they may be assigned in the part of country which they may not desire. Every effort is being made in this office to assign a nurse as to the preference of her assignment, and the location of the hospital, as well as the size

the hospital. However, because of the service needs, it is not always possible to grant her choice. Nurses are not always willing to take the risk, but in the office we amend and revoke a great many orders daily, trying to place them as to their preferences, so that they themselves will advise other nurses to join the Army Nurse Corps.

Our promotion policy at this time is a detriment to nurses coming in on extended active duty. We have not had provisions to promote the Reserve nurse any higher than a 1st Lieutenant since February 1947. However, we did temporarily promote nurses with seven years service in the Regular Army, until such time that we could set up an examination policy prescribed by The Surgeon General. This caused great concern among our Reserve nurses; they felt that they had been forgotten, and that no provision was made for their advancement. Steps have been made to correct this, and it is hoped that P & A will soon authorize us to make temporary promotions in all the Army Nurse Corps.

We have worked out our projected nurse personnel needs on bed capacity, and not on actual number of patients. We find that this is necessary so that we can get enough nurses to take care of our dependents and clinics. The number of nurses needed on the basis of expansion of beds in areas is an additional 2,500 to the already 1,500 we are presently short. Where are these nurses coming from? Presently we are not going to get Army nurses to fill this need. Our only alternative is to utilize civilian nurses. It seems strange that we are able to employ civilian nurses in Army hospitals, but they are not interested in coming into the Army. This is because they work five days a week, the salary is good, and they can work in any hospital to their liking.

Our plan is to remove some of the Army nurses in our larger hospitals where civilian nurses are available, and replace them with civilian nurses, and transfer the Army nurses to posts where there may not be civilian nurses available. Let me point out that civilian nurses will be counted against your military quota. Some of the Army hospitals may have only a skeleton staff of Army nurses remaining. If you have a hospital near a city where you may obtain civilian nurses, we would appreciate your requesting an authorization for civilian nurses so that you may be able to assign some of your Army nurses within your area to a post where civilian nurses are not available. If we are to utilize the civilian nurses entirely for the expansion, the required number would be approximately 4,000 because we must figure one and one-half civilian nurse for every Army nurse. This brings up our next topic, and that is conservation of professional nursing personnel. It is evident that immediate steps must be taken to conserve nursing service. We find in making rounds through our hospitals, that the nurses are doing non-professional nursing duties. The nurses have offered no complaint this past year, during which time they have substituted in many instances, and carried out not only their work, but the work which should have delegated to other personnel. They are to be commended, and we have been most proud of the splendid job our nurses have done during this acute personnel shortage. The blame is on the difficulty in getting

nurses on duty and not with those who are now on duty. Every effort should be made to conserve professional nursing service. It is hoped that some wards may be combined so that the nurses can take care of more patients in fewer wards.

We can no longer use nurses in our convalescent sections to see that patients are in their wards on time for meals, and that discipline is maintained. It is necessary that we use nurses only in their profession to maintain a high standard of nursing service. It is hoped that we can conserve the nursing service by combining some of our scattered clinics, and putting civilian nurses in our clinics. These are only suggestions on which we hope you will be able to advise us.

There are many ways in which you may help in our procurement program. We are interested and will help in every way possible to improve the personnel problems within your hospital, and to improve the living conditions of the nurses. In all instances we have worked very closely with the state and national organizations in soliciting their help in various programs. At the present time the American Nurses Association is endeavoring to set up a quota system within the state in an effort to supply us with the necessary nurses. We are working very closely with the civilian associations, and trying to appoint an official of their association to work with the Army nurse. Quotas to be worked out on a percentage basis would be assigned to each state on the basis of the number of nurses available in the state, and the number of civilian hospitals to be staffed. This will be of interest to you because you may be asked to supply a nurse who will work with the state nurses association.

At this time, or any time during this conference, I would like suggestions from this group as to how we may better utilize our present nursing personnel and suggestions for procurement.

We need your help, and we are grateful for any suggestions.

Thank you for your attention.

COLONEL GORIUP:- MSC Personnel.

The shortage of Medical Corps officers, plus the increased utilization of Medical Service Corps officers, plus an overall increase in the Army and Air Forces, has created a shortage in the Medical Service Corps. In the early months of this year of 1948 we were overextended, had a surplus, which caused us to close the receiving of applications for recall to active duty. About May of this year a shortage in Medical Service Corps officers became apparent. At that time we reviewed and re-reviewed about 500 applications we had on file and contacted those people we considered qualified to try to interest them in returning to active duty. We did not get a very good response. It was in May that we received procurement for recall of 300 officers. After the passage

of the Selective Service Act it was increased by 500, for a total of 800 recalls to active duty. At this time the condition of MSC is such that we are overextended in Pharmacy Supply and Administration, which caused us to close Competitive Tours for the Regular Army. I believe that created a situation whereby a lot of well qualified MSC officers left the service because we had nothing to offer them. I also believe that is one of the main reasons why we don't receive too many applications from well qualified MSC's in civilian life to come back on active duty. At the present time we are still short in certain sections. In the Optometry Section we have a procurement objective of 20 and have 1 on duty; in Engineers we have an objective of 80, and have 16; in Allied Science Section we have an objective of 300 and have about 63 on duty today in the Regular Army. I believe that one of the reasons why we can't attract people in the science groups is they still have some apprehension of being grouped with MSC's and appear most apprehensive that they are not going to be utilized in their specialty, science. I believe we can disprove that by using the 60 or so we have now intelligently. I urge everyone to please make every effort to keep those in the so-called "ology" groups in their specialty. From April through July we have received 234 applications for recall to active duty. Of that number we have accepted 129. We have a committee and think we are very conscientious and meticulous in reviewing their recommendations. In the main, we do a good job - in fact, I believe we are being criticized for the great percentage of rejects, so perhaps we are being too critical. I have been informed by Colonel Liston that he has one of his MSC officers about to be tried and Colonel Healey has one about to go to jail. We believe the biggest help you can be to us (we have only the 201 file, and have purposely made the committee large and try to leave no stone unturned to see that those picked are the best possible of the ones who apply) is to be specific and not pull your punches on your indorsements. I believe that our best qualified people, who were Reserves during the war, are now back home, well entrenched, and are reluctant to come back when we don't have too much to offer in the way of a Regular Army commission. The Army is putting on an intensive publicity program to interest qualified Reserve officers to return to active duty. In addition, the Surgeon General's Office has its own publicity program. A great number of well qualified Reserve Officers returned to the enlisted ranks. I believe we should make every effort to interest the best qualified to request extended active duty in an officer status. In order that The Surgeon General's Committee may make an intelligent evaluation of this personnel, I urge that the Class II Commanders, whenever possible, interview each applicant. It is also desired that all favorable or unfavorable comments be reflected in your indorsement to the application. Only in this way can we insure that the best qualified are placed on active duty. Some other possible sources for recall to active duty will be those individuals commissioned under Circular 101, which authorizes direct appointment in the Reserve Corps of enlisted men who served during the war in the first three grades. We have gotten 99 applications. Once more I would like to point out that of those MSC's initially integrated into the Regular Army that well over two years of their probational period has passed. It gives us one

more year to evaluate them. They should be constantly evaluated and re-evaluated. We believe another previously untapped source will be those individuals commissioned under Circular 210 dated 14 July. It has just been published and will implement Public Law 337, whereby we will be able to offer direct appointments to those people who had no prior military service, but are otherwise qualified. We mentioned it 5 or 6 months ago in civilian meetings with professional groups. We have in excess of 500 letters of interst and the gratifying part is that about 35% are from the "ology" group. We believe that as soon as we are able to supply these people with the necessary forms, directions, etc., we will probably find a good number of individuals who will desire to come on active duty, especially in the science group. One other source is the transfer of Reserve officers from other branches into the MSC who appear to be fully professionally qualified. We have to date transferred 126 officers in this fashion.

COLONEL VOGEL:-WMSC Personnel.

For several months this office has been conducting a vigorous campaign not only to interest new applicants in appointments in the Women's Medical Specialist Corps in the Regular Army but also in the Officers' Reserve Corps. In connection with this program radio broadcasts, newspaper articles and television which have been utilized have aroused considerable interest. In view of the fact that this program was initiated when many individuals considered to be potential candidates were on summer vacations, tangible results from this program are not expected for several weeks. If the degree of interest continues at the rate indicated by correspondence recently received in this office, it is expected that procurement will soon be materially improved.

Wide distribution will be given to an illustrated brochure concerning the Women's Medical Specialist Corps which will be available in the near future. As soon as published, packets will be mailed to the Class II Installations for local distribution. This brochure will contain pertinent information regarding the requirements for appointment and a brief description of the duties of officers in each of the Sections of this Corps.

In connection with recruitment, it is believed that Class II installations situated near large educational institutions can be of considerable assistance. Personal contacts and observation in general hospitals are believed to be a very effective means of interesting individuals in a career in the Army. For example, the Commanding Officer of McCornack General Hospital could invite the students attending Physical Therapy or Occupational Therapy Courses in Los Angeles to spend a day at his hospital not only in observing Physical Therapy and Occupational Therapy activities but also in a tour of the entire hsopital. This type of local publicity could be accomplished in several of general hospitals, for all three (3) groups of specialists in the Women's Medical Specialist Corps.

In order to give you a picture of the efforts which have been made to improve the procurement situation, I shall deal with the groups separately beginning with the Dietitian Section.

DIETITIAN SECTION

During the past year dietitians have been utilized to better advantage in general hospitals than in previous years. To meet the shortage of commissioned dietitians and trained enlisted personnel, civilian men and women, who have had some previous food experience, have been employed in some hospitals. This personnel has taken over many of the routine duties thus permitting the dietitian to devote the major portion of her time to the supervision of the Food Service Program. With participation in training programs and further experience, it is believed that this personnel can be utilized to even better advantage.

Planning:

Short Range:

Letters containing information regarding opportunities, both in the Regular Army and Officers' Reserve Corps, have been sent to all former Medical Department dietitians. At the present time 200 have accepted Officers' Reserve Corps commissions and requested inactive status.

The Chief of the Dietitian Section has contacted the president of the state dietetic associations offering to provide speakers for their meetings, and Dietitians from several of the general hospitals have participated in local meetings. A dietitian attended the American Home Economics Convention in June to familiarize Deans of School of Home Economics with the training program for dietetic interns conducted by the Medical Department. The training course at Johns Hopkins Hospital was also reviewed. In all of these contacts information was disseminated regarding the opportunities for a career as an Army dietitian.

A recruitment rally at Fort Jay, for approximately 50 dietetic interns in training in the New York area, proved to be a most interesting experiment. These interns, who were invited by the Commanding Officer of the hospital to visit the station, were given a sight-seeing trip around the Island, and oriented to the various activities of an Army Post. In addition, they were escorted through the entire hospital, and the functions of the dietitian were explained in detail. Interest displayed at this rally, and correspondence received in this office, indicate that such meetings not only promote good public relations, but also are excellent recruiting measures.

Articles prepared by the dietitian section which have also been published in the American Dietetic Association Journal, have also stimulated considerable interest.

Long Range:

The training course for dietetic interns, formerly conducted for civilian students at the Brooke Army Medical Center, in the future will be available only to individuals interested in the Regular Army as a career. Like the courses for Physical Therapists and Occupational Therapists, individuals accepted for this training are commissioned in the Officers Reserve Corps, and must sign a Category II statement and state in writing that they will apply for commissions in the Regular Army. Completion of the Basic Medical Department Female Officers' Course is a prerequisite for this 12 months course, which will be followed by actual experience as a dietitian in the Medical Department. After not less than 6 months of such experience these officers will be expected to make application for the Regular Army. Considerable interest has been shown in this program, and it is expected that the quota for the September class will be filled.

Four dietitians will attend meetings of the American Hospital Association institute on hospital personnel relations in New York in October. Information acquired at this institute will be valuable to chief dietitians who are responsible for planning and executing training programs for civilian personnel.

During the coming year it is planned that an officer from the dietitian section will visit selected colleges and universities not only to stimulate interest in the training of dietetic interns, but also to familiarize students with the opportunities for service in the Officers' Reserve Corps and the Regular Army. Plans are under way to conduct an active recruiting campaign at the dietetic association meeting in Boston in October.

PHYSICAL THERAPIST SECTION

Planning:

Short Range:

The number of AUS officers recalled to extended active duty has shown a definite increase and it seems reasonable to assume that interest will continue at the present rate. Former Army Physical Therapists have been contacted by letter and furnished a fact sheet regarding appointment in the Officers' Reserve Corps and opportunities for extended active duty. This information has also been forwarded to Physical Therapists without former military service and to all graduates of approved civilian Physical Therapy Schools. Articles concerning the opportunity for extended active duty have also been published in the Physical Therapy Review as well as in the monthly News Letter published by that organization. To date, 148 Physical Therapists have accepted Officers' Reserve Corps commissions requesting inactive status.

Long Range:

Long range planning includes the resumption of the Physical Therapy

training course at Brooke Army Medical Center. This course will be available to individuals otherwise qualified, who are graduates of a four (4) year college course with a major in Physical Education. The first group of students appointed as second lieutenants in the Officers' Reserve Corps for the purpose of completing this training will report at the Brooke Army Medical Center on 1 September. After completion of the Basic Female Officers' Course, the course in Physical Therapy will begin on 1 November. To dessiminate information regarding this program over one hundred (100) colleges were contacted by letter and furnished packets containing application blanks and information material for distribution to interested students. In spite of the fact that this information was not available until the last week in May, twelve (12) outstanding college graduates have to date been selected for this course. At the present time it is anticipated that only one (1) such course will be given annually. However, since the course is arranged in two (2) parts, six (6) months of didactic training followed by a six (6) months applicatory phase in selected general hospitals, it is sufficiently flexible to permit two (2) such courses to be conducted annually if necessary.

It is anticipated that a three (3) months course for enlisted physical therapy technicians (SSN 072) will begin at the Brooke Army Medical Center early in 1949. Since the details of the program have not yet been completed, formal announcement regarding this course has not been made. Graduates of such courses will be of considerable assistance in relieving physical therapists of routine duties which are time-consuming.

OCCUPATIONAL THERAPIST SECTION

The Occupational Therapist Section is growing although it is still markedly under strength. On 15 June 1948 there were 34 commissioned Occupational Therapists on duty in Class II Installations. It is expected that this number will be increased to 48 by the middle of September. This number will not meet the need however. It is therefore essential that the civilian Occupational Therapists who are now on duty in the general hospitals remain until such a time as they can be replaced by commissioned personnel. At the same time, it is urged that civilian Occupational Therapists now employed in general hospitals make application for appointment in the Officers' Reserve Corps.

A steady recruiting program is being carried out. Members of the American Occupational Therapy Association as well as the directors of all approved schools of Occupational Therapy have been contacted by letter and furnished information regarding the professional and personal advantages of a military career in this speciality.

This year for the first time the Medical Department will be represented by a group of military Occupational Therapists at the annual convention of the American Occupational Therapy Association in New York in September. It is believed that it would be highly advantageous to pro-

curement if a group of uniformed Occupational Therapists could be present. It is strongly recommended therefore that commissioned Occupational Therapists whose services can be spared be urged to attend this convention in order to assist in an extensive recruitment drive.

The Occupational Therapy training program established by SGO Circular 164 is still in operation, though on a small scale. It is expected that this program will be accelerated. The number of applications recently received appears to indicate that the interest in this program is steadily increasing.

Late in 1949 it is anticipated that a 12 months' internship for Occupational Therapy students will be initiated in selected general hospitals. This course will be available to individuals, otherwise qualified, who have completed 4 years of college and who are desirous of completing the clinical phase of the course in an Army hospital. Persons granted Reserve commissions for that purpose will be limited to those who have expressed a desire in writing to enter the Regular Army.

Plans are also underway to establish a course for training enlisted technicians in the field of Occupational Therapy.

MAJOR MONNEN:-Enlisted Personnel.

First, I would like to show you a chart which gives the overall picture of our general hospital personnel.

(Major Monnen then gave a graphic description of information contained on the chart regarding enlisted personnel.)

Our enlisted personnel has dropped considerably in the last year, from 13,389 down to about 8,338. At this time there is a critical shortage of Medical Department trained enlisted personnel, but every effort is being made by us and the General Staff to remedy this. It was hoped that with the passage of the Selective Service Act we would get a great number of enlisted men soon. As you know, it authorized the induction of a great many 18-year olds. They will be of no value to the Medical Department as they cannot be used for labor type duties, and hospital orderlies are interpreted as being in that category. We probably will get very few, if any; however, when the draft is finally put into effect we will get relief when those drafted for 21 months come in.

I would like to mention the Tables of Distribution. All of you have submitted them to us and we have sent them on to the General Staff. I would like to speak especially of enlisted personnel. It is planned to provide an automatic requisitioning system based on Tables of Distribution. Your present system will go out. It will show the personnel by grade and MOS that you are short, and they will be automatically furnished you. Today we are getting in requisitions for personnel you

people are asking for which are not in the Tables of Distribution submitted, and I believe if a little more effort were put into the preparation of them you would get the personnel you needed, when you need them.

I would like to say something about Department of the Army Circular 202. All of you should read it. It has to do with enlisted grade structure, pay, titles, etc., and I should also like to call your attention to Paragraph 88, which takes away from you the authority to promote enlisted men in the first three grades. I am informed by the General Staff that the authority for promotion cannot be delegated but must be handled by this office.

RECESS

1st part of afternoon
session - 4 August 1948

MR. LA CROSS:- Employment of Civilian Doctors and Dentists.

I feel it is hardly necessary for me to tell you commanding officers of our well run general hospitals how to procure civilian doctors, because it is just a slight variation from what you are doing every day with civilian employees. These civilian doctors and dentists will be exactly the same as other civilian employees, once they are employed. I just want to tell you of the slight variation in the procedure in getting them on your staff. The first thing to do, as you do with all other civilian positions, is to get the position established; that is, write up the job sheet, get the Classification Analyst to allocate that position, and then you are ready to make your contacts in order to get a doctor to fill that particular job. Your civilian personnel officer will know that the first step after getting the job established is to see if Civil Service has any doctors on the local register. They generally don't! Then you will want to contact the doctors locally to see if they are willing to work for the pay and do the job you have established. That may take some time. From the lack of doctors already employed, the indications are there will not be much of a rush! If, however, you do have a doctor or dentist willing and ready to go to work, we would like you to either call by phone or send a TWX to this office, asking for authority to employ the man you have, or the woman (that question was raised this morning) whom you have available to work for you as a doctor or dentist. You will be given authority to employ the individual immediately, either by phone or TWX, which will increase your ceiling and grade group authorized automatically. You will have funds available to pay the individual, and if your funds are insufficient a request for additional funds will result in your getting your M&HD money increased. In establishing the position, getting it classified, specifications to be followed in arriving at the grade are published by the Civil Service Commission in Series P-640 for doctors and P-510 for dentists. I want to emphasize that you at your hospitals have the authority to establish the position, set the final grade, and then ask us for authority to employ the individual you have at hand so he can be placed on the rolls. The reason we are not making the allotment of physicians, both as to ceiling and grade group, immediately is that we have been limited in funds by higher authority to 150 for the entire Medical Department. When we see we are employing that 150, then we can go to higher authority to get an increase in our allotment. It is expected that 70% of your grades will be in P-4. That has a per annum rate of $5232.00, a daily rate of $20.12 and an hourly rate of $2.51. That is your P-4 staff physician or dentist. You may be able to get some specialists which would normally carry a P-5 rating, and the per annum salary is $6235.20, a daily rate of $23.98 and an hourly rate of $2.99. It is considered rare that you will have anyone in a higher grade. If you should appoint a doctor or dentist as chief of one of your services, he would have a specialty and administrative responsibility which might bring the grade up to P-6. That pays $7432.20

per year, $28.58 a day and $3.57 per hour. These rates, of course, are not comparable to what many doctors are making on the outside, but this is a means we are now making available to you for procurement of these doctors, either on a full time or a part time basis. All other procedures in the employment of doctors are exactly the same as the employment of all other civilian employees, with which you have extended experience. Are there any questions about this procurement?

GENERAL WILLIS:

You say the first thing is to establish the position, work up the job sheet, etc. Now in positions we have had established, with job sheets worked up, and the individual employed from as much as 2 to 26 years, they have been recently regraded. What assurance have we that the same thing will not happen to any position we write up now?

MR. LA CROSS:

The reason the positions have been regraded is because of a change in the duties that have been assigned to the individuals concerned. If you do not change the duties of these doctors, then there would be no question of regrading.

GENERAL WILLIS:

That is what you think is happening, but it is not true. Now, the second question is, you say we send a TWX for authority to employ. That entails a delay. You say you get an answer back to us right away, but that is not true. Why not give a block of numbers to overcome this and let me employ and then notify you. I think, personally, that is one of our greatest drawbacks - the interminable delay in getting an answer.

MR. LA CROSS:

If you have had experience of this sort, being delayed, I would suggest that, since Brooke talks with the Surgeon General's Office almost daily, authorization can be given at the moment we are talking with you, so there will be absolutely no delay.

GENERAL OFFUTT:

In employing part time men, they are paid an hourly rate, are they?

MR. LA CROSS:

Yes, Sir, just a fraction of their day.

COLONEL GATES:

Is there any hope of deviation from the Civil Service rate of pay? We can procure but not at that rate.

COLONEL ROBINSON:

I would like to say this. There is no question at all but that we could hire doctors if we could pay what they demand, but what would happen to the morale of the Army officers if we did that? Further, I might say we have a bill already prepared and in the hands of our Liaison Division to employ without Civil Service.

COLONEL GATES:

But that doesn't give us any assistance now.

GENERAL OFFUTT:

How do Civil Service rates compare with Veterans'?

MR. LA CROSS:

They are the same except Veterans' has 25% for specialists.

COLONEL REYER:

I have a schedule from Veterans' at Dallas, showing their rates of pay, physical examination, etc. They are starting at P-5, $5905.00 per annum, P-6 paying $7102.00. On the physical, they don't care whether they have anything except hands and feet intact - no mental examination and no physical examination other than that.

MR. LA CROSS:

These rates you just quoted were the salaries before the current pay raise came out.

COLONEL BREWER:

They don't have to conform to Civil Service.

COLONEL WELCH:

Why do you think 70% would be selected in grade 4, because of the ceiling on funds?

MR. LA CROSS:

No, the reason we think they will be in P-4 is because that is the grade for a regular staff doctor in a hospital and not chief of a branch or service.

COLONEL REYES:

You gave us specifications for a chief of service. How about chief of a section?

MR. LA CROSS:

That would probably be a P-5 or P-6.

COLONEL REYER:

I am highly in accord with Colonel Robinson on morale being lost. You have a dispensary physician and the Civil Service rate of 6 is a couple of hundred dollars higher than a Captain in the Army with one fogy. These people are going to have to work with Regular Army people and it is going to be a mess but we are going to have to use them.

MR. LA CROSS:

In determining that we were going to use regular Civil Service in employment, consideration was given to the effect it would have on our procurement of doctors themselves and, also, if we used other methods available, the effect it would have on the Army.

GENERAL OFFUTT:

These men would still be on a five day week?

MR. LA CROSS:

Yes, Sir.

COLONEL REYER:

And at night 1-1/2 pay?

MR. LA CROSS:

Don't worry about working them overtime. They will get paid the overtime rate. At these grades it is considerably less than the regular hourly rate during the day. A P-6 gets $28.58 per day. When he works overtime for a day he gets $12.08 or $1.51 per hour, as compared with $3.57 his straight time hourly rate.

COLONEL LISTON:

But they don't have to do overtime if they don't want to. You can't control that.

MR. LA CROSS:

They will be the same as your other civilian employees. If you ask your laboratory technician to work overtime he doesn't tell you to go and stay put, he works. We would presume as commanding officers that you would have the same control over these doctors as over your other civilian employees.

COLONEL LISTON:

I do have some civilians and they live a long distance away, and I can't get them back. A lot of these doctors willing to come on part time under Civil Service are still intending to maintain their outside practice and I doubt if their availability would be high outside of that 40 hours. Is there any way you have any pressure on his services? If he doesn't want to work over 40 hours you can't give him an unsatisfactory report if he doesn't work over 40. There is nothing in the law that requires him to work.

MR. LA CROSS:

That's true.

GENERAL ARMSTRONG:

I hope you don't misunderstand. We are not saying this is an ideal situation at all. It is merely one of the 5-1/2 pages of suggestions by which we can in some small way try to meet this situation. One of the things we hear most frequently from civilian doctors, Congressmen, people on the General Staff, etc., is, "Well, why don't you hire civilian doctors if you know a place where you can hire them?" I am not going into the merits or demerits of the plan. We cannot run the Medical Service by hiring civilian doctors. We have asked for $19,000,000.

in the 1950 budget to have the mouths of every enlistee and inductee rehabilitated so the first year in the service the dentists will have nothing to do. You can't send him to a civilian doctor so we can have nothing to do for a year. We can't run the Medical Service with civilians. On the other hand, we asked for and got these 150 slots. They were gotten primarily for the Air Command and Area surgeons, thinking maybe we could utilize them. Why 150? In the whole Army we thought we might be able to fill that many, and we felt that number would not interfere with the morale of the men in uniform. If we do find 150, even part time, you might be able to give up 75 in the larger establishments and thus run the smaller establishments. You will have trouble. On the other hand, in San Francisco you might find some youngsters, who do not qualify for consultants and who are trying to get started in practice, who would like a 4-hour job. If you could get two like that, then you could give Robinson a medical officer. In the whole of the Sixth Army they have one man they can shuffle around when any of the others are sick. Twice we have tried to get a system like Veterans' to hire doctors regardless of Civil Service. We are trying again. This is just another stop-gap. If you can utilize it, it will help.

COLONEL MORGAN AND COMMITTEE:

ADMINISTRATIVE PROCEDURES AND STAFFING OF
HOSPITALS TO CONSERVE PERSONNEL

Report of an S. G. O. Special Committee ----- 4 August 1948

Members:

Colonel Oramel H. Stanley, MC, CO, Oliver GH, Chairman
Colonel Harry A. Clark, MC, CO, Murphy GH, Member
Colonel Clifford V. Morgan, MC, Deputy Post Commander, AMC, Recorder

General Bliss: This Special Committee Report is respectfully submitted in response to a directive of the Acting Surgeon General, Brigadier General George E. Armstrong, 29 July 1948. The original mission was to consider means of expediting the disposition of patients from hospitals and thereby conserve personnel. This action is imperative in view of our present crisis. Since The Surgeon General's Staff is devoting its major efforts to the solution of this problem, General Armstrong implored the Committee to consider any administrative procedure and staff problem which would aid in the conservation efforts. Our thinking has considered changes of existing procedures and policies on three levels, namely: (a) That of the Hospital Commander; (b) That of The Surgeon General's Office; and (c) That of the General Staff.

There has been little opposition to accepting the fact that the faults of administrative procedures lie primarily in the laps of the commanding officers. The chief attenuating circumstance is the caliber of the subordinate personnel. Many lack experience and confidence to command and control their particular service, section or unit. The commanding officer is not at liberty to hire and fire as he sees fit, but is like the poor carpenter, who must use the tools which are given to him. These statements must not be interpreted as deroratory to our officers. Loyalty and effort tend to compensate for deficiencies in know-how. No commanding officer of an organized social unit can demonstrate his full abilities as a leader when he cannot pick to the fullest extent his own staff. This responsibility lies in the SGO, the General Staff and even Congress, who determine the laws which attract men to the military service.

The responsibilities for the conservation of personnel also lie on all levels. Few of our hospital commanders are in a position to admit that they have too many personnel. They have all been harrassed for the past two years by manpower experts, few of which know much about a hospital and none of which are experienced C. O.'s. The SGO statistics for the end of May 1948 reveal that the operating personnel ratios per 100 authorized patient capacity is 107.2 in our general hospitals. This is exceedingly low when compared with a survey of

ratios of personnel to patients in civilian hospitals made by Warren P. Morrill, M.D., American Hospital Association in January 1940 - 8 years ago. At that time the average in all U. S. civilian hospitals was 121. Texas and Colorado were the lowest at 108; Pennsylvania 110; Georgia 121; Massachusetts 133; California 142; and the District of Columbia 170. The author stated that "figures were l w because of unaccounted volunteer or unpaid services;" and his statistics did not include visiting staff physicians or private nurses. (Reprint of this article has previously been furnished to the Personnel Division, SGO). Civilian hospital ratios, as well as military, have no doubt increased in the past eight years, due primarily to the 8-hour day and 40-hour week. In comparison to them the military hospitals are operating with a high degree of efficiency. However, we must not overlook any means of improvement. This requires a constant attention to job analyses, personnel qualifications, work measurements, organization, personnel supervision and procedural short-cuts. The latter is probably the least controllable at hospital levels, since, in nearly all instances, the procedures are established by the policies and directives of higher authorities.. You might be interested in learning that a study made by one of us, over two years ago, revealed that 240 weekly, bi-weekly, monthly, quarterly, semi-annually and annual reports were required from each of our independent general hospitals to other staff; including the SGO, Armies, General Staff, Depots, Supply Arms and Services, and other agencies involved in the control of the operation of a military hospital. It is realized, of course, that an organization as big as the Army must exercise rigid controls of its operations. Few of these reports were cause for complaint, but it must be realized by all concerned that the compilation and rendition of these reports demand an overhead. Therefore, our plea to all staff officers is to think twice before requiring any additional reports and then don't do it unless absolutely necessary; realizing at the same time, that as staff officers, you could exert even greater influence in the conservation of personnel by spending your time in curtailing the reports now required. In essence, the responsibility for simplifying practices lies on the staff level.

It must be realized by all that the absolute control of the assignment and distribution of personnel is not within the prerogative of the hospital commanding officer. There are many jobs which are specified by higher authority, and many missions to be performed, for which additional personnel are not always forthcoming from within the personnel ceilings allocated to them. During the war, certain luxurious services and practices were instituted which could hardly be considered as paramount to the primary mission of the care of the sick. There is always the tendency to allow these activities to continue. Every effort must be made to abolish these non-essentials. Other activities have taken on revised importance; a typical example during the past year being the reorganization of Food Service Administration. We also venture the observation from the field, that there is a tendency on the part of the divisions of The Surgeon General's Office to operate independently in the promulgation of their missions, projects

and professional enterprises without correlation with the Personnel, Fiscal and Supply Divisions; the wherewithal for which has not been anticipated or made available. The plea is, therefore, made that closer staff work be instituted to provide for this coordination and that there be no newly assigned missions without the means.

Per AR 40-5, last issued 22 years ago, "The mission of the Medical Department is the conservation of manpower - the preservation of the strength of the military forces." This concept is certainly apropos to the Medical Department itself, as a component of the Army as a whole, and is far bigger than the primary duty, namely, "the medical, surgical and dental care of the sick and wounded personnel," which has existed since our creation by the Continental Congress in 1775 - 173 years ago. In fact the Command and General Staff School and the National War College would impress upon you that the primary mission of the Army, and hence the Medical Department, in peace time, should be "To prepare for war." It is this situation in which we find ourselves today. If this mission were not so, we would have less excuse for maintaining our general hospitals in time of peace. It is conceivable that Johns Hopkins could be enlarged to assume the functions of Walter Reed General Hospital, that the University of Pennsylvania could be responsible for the patients now in Tilton and Valley Forge, that Harvard could absorb Murphy General Hospital, the University of Michigan could take over Percy Jones, the University of California take over Letterman and so on in many regions of the United States. However, this would not fulfill the mission of the Medical Department, which in peace is to prepare itself for time of war.

It is to be noted that the Army recognizes that besides the primary function of the care of the sick, it has many other important functions, including:

(a) The proper selection, classification and training of the Medical Department personnel (both in and out of the Regular Army);

(b) The research and experimentation connected with diseases and sanitation and those connected with the development and improvement of Medical Department materiel; and

(c) Production or procurement, storage, issue and maintenance of all supplies and equipment used by the Medical Department.

Recognizing these paramount functions, the Committee predicates the balance of its report upon the premises: (1) That training must be completed to the maximum; (2) That the PMS&T assignments for ROTC's in medical schools will be continued; (3) That research and development must be supported; and (4) That dependent care must be recognized as an obligation of the Medical Department, even though curtailed.

We must not forsake our training program even in civilian institutions. Anticipating that by June 1949 the strength of the Army and Air Force will be nearly 1,400,000 persons, they will require the medical care of approximately 8,000 doctors. By June our net new requirements for doctors will be about 4,000. Since we have only about 40 medical

officers in training in civilian institutions, which is only one per cent of the net increased requirements, it is not worthy to consider withdrawing these medical officers from this training program to meet the demand.

Dependent care is one of the best methods of internal public relations. As a part of a socialized group, we owe it to the Army. The average competent Army officer or enlisted man could not afford, with their low salaries and high cost of living, to enter or remain in the Army if dependent care were not part of their compensation. Besides the civilian medical profession is in no position to take on the additional load which would otherwise be thrown upon them. However, it behooves us to consider always, the early discharge of dependents from the hospital, as a part of the next problem which considers expediting the disposition of patients from our Army hospitals.

Our hospital commanders have been given almost complete authority in regard to admissions of patients other than military (Par. 6, AR 40-590). They have also been given the means for the disposition of patients (Par. 7, AR 40-590); disposition of the insane (AR 600-505); discharge of enlisted men by CDD (AR 615-361); the use of the Disposition Board (AR 40-590); the reference of officers to the Army Retirement Board (AR 605-250); the transfer of enlisted patients to the Veterans Administration facilities; and other established procedures covering most every conceivable case. Hence it is up to him to constantly probe the professional services to see that these dispositions are accomplished expeditiously.

However, there are two documents which this Committee believes should be changed. The first one is Sec. II, SGO Cir. 73, 14 June 1948 (Incl. #1). It was based upon Sec. I, Public Law 350, 80th Congress. This Circular states in part, Par. 2: * * * * "Sick leave may not be granted to an individual who has appeared before a retiring board and is then awaiting final action of the Department of the Army;" We recommend that this and the 4th paragraph be deleted. The purpose of this directive appears to have been to force retiring officers to consume their accumulated leave prior to separation, but this has not operated effectively. The officers hide their time occupying beds in the hospitals in order that they may receive the monetary credits of their accumulated leave upon departure. This has been brought to the attention of the Hospital Division and the Physical Standards Division, SGO; to the attention of Lt. Col. P. L. Hooper and Lt. Col. Thompson of the Personnel and Administration Division, General Staff; and to Lt. Col. Cullitan and Captain Long, the Adjutant General's Office; as well as to Lt. Col. William H. Purdin, Separation Branch, AGO. All of them have promised to give it their immediate attention. This condition not only causes the loss of hospital beds and the waste of personnel, but is economically unsound. The Physical Standards Division, SGO, received in FY 1948 a total of 5,533 cases for recommendation and decision as to retirement from the Army (Incls. #2, #3, & #4). The average delay was six weeks from the time these records left the Army Retirement Board until the orders were received and the officer separated.

The average cost of hospital care is now about $14.00 per day; the average salary of the officers retired last year was approximately $11.00 per day. The delay thereby cost the government $25.00 per day per officer, or $138,000 per day for the 5,533 pending cases. Averaging 42 days each, the total cost is a rather startling figure of $5,810,000 in FY 1948. Therefore, it behooves the SGO and the General Staff to reduce this expenditure. The Committee urges that prompt and effective steps be taken immediately. No doubt even a greater savings could be accomplished within the hospitals themselves, prior to the time that these cases were referred to the ARB. Therefore, it also behooves every hospital commander to expedite the clinical surveys, treatment and appearance of these patients before the Disposition Board and then to the Army Retirement Board.

In this connection consideration should be given to the reduction of the number of retirement boards. Six of our 13 general hospitals averaged less than 4 cases per week over the past six months. Hence, it seems feasible to reduce the total number of boards to 7. The transfer of a small number of cases would be cheaper than paying the staffs required. One caution should be observed to prevent the indiscriminate transfer of cases, namely, that these cases would be transferred only when the Disposition Board has recommended their appearance before an Army Retirement Board.

There were on 30 June, 2,300 officer patients in our ZI hospitals. You should not forget that the hospitalization of these patients was costing the government $60,000 per day.

The next document we want changed is WD Cir. No. 238, dated 30 August 1947. (Changed by Cir. Nos. 12 and 68, Department of the Army 1947). Cir. No. 238 concerns the Assignment of Hospital Patients. Paragraph 3 covers the transfer of personnel upon completion of hospitalization. We have no argument in the disposition of personnel carried as "attached from other organizations." This is in substance the station hospital type of case. We are deeply concerned about the disposition of personnel carried as "assigned," which is the Detachment of Patients. Par. 3b (1) (b) requires the commanding officer of a hospital to give The Adjutant General 15 days to determine future assignments of officers and 5 days for enlisted men. The AGO has one point of criticism concerning our general hospitals who write letters instead of sending TWX's for these disposition orders. However, the experience at our general hospitals seem to be that the time required for orders on officers is nearly 20 days and for enlisted men nearly 10 days. Statistics are not available as to the tremendous, unnecessary hospital costs that this involves. We do know that during FY 1948 the ZI hospitals disposed of 76,000 patients, 60 per cent from general hospitals, of which a great number must have had to await orders. The above named officers in AGO and P & A Division have been acquainted with these facts. In order to vacate our beds and relieve administrative overhead, as well as cost to the government, and difficulties arising from this type of patient loafing around the hospitals, the Committee recommends that the hospitals be

relieved of this replacement center function. One solution the Committee proposes is that the commanding officers of the hospitals be allowed to transfer these cases upon completion of hospitalization to the nearest post of their branch, the CO of which will report them to The Adjutant General for orders. Another way would be for each Army to designate one or more places for transfer. In either event we could clear our beds and the military personnel could be used; at the same time be associated with their active duty comrades. It is believed that this will increase their morale and be an incentive to better soldiering.

Enlisted men.- Subparagraph 3b (1)(b)(2) states that "enlisted men who entered hospital from Zone of Interior installations, will be returned to the organization from which admitted, provided organization commander concerned has requested such reassignment in writing.". Obviously these organizational commanders want replacements when they lose men to the hospitals, for which they cannot be blamed. However, it also gives them an out for getting rid of every man they don't want, particularly those undesirables who ought to be discharged from the Army under AR 615-368 or AR 615-369. The Committee does not feel that the Medical Department should be required to wash such administrative linen for the line.

Another document which should be re-read repeatedly by every hospital commander is AR 615-361, concerning medical discharge of enlisted personnel. Every commanding officer of a named general hospital has authority under Par. 7, AR 615-360 to discharge enlisted personnel for cause prior to expiration of their term of service. Every general hospital, without exception no doubt, has many enlisted patients who will never return to active duty. Our professional staff seems to have a stagnant inertia in getting patients out of the hospital, particularly since we have instituted the training program. Every case should be reconsidered in terms of its value to the teaching program. There is certainly a time when each case ceases to materially contribute to this. There also seems to be a wide misconception as to what constitutes maximum hospital benefits, and particularly an indefinite interpretation as to what is expected under AR 615-361. It is sufficiently important to review now, Par. 1b, which states, "When an individual with less than 20 years service becomes unfit for military service because of disability he will be hospitalized until his condition has reached the point where he can be returned to duty or until it can be determined that the disability is such that rehabilitation for military service is not feasible." The first important point to determine, therefore, is whether or not this soldier will ever return to duty. The next point is how long shall we allow him to remain in a military hospital.

Par. 1c (1) continues, "No individual with a disability incurred in line of duty except those listed below will be discharged on CDD until maximum hospital benefit has been attained." Then individuals having certain types of diseases such as tuberculosis, chronic psychosis, chronic degenerative neurological diseases will not be retained until maximum hospital benefit has been attained. A few types of cases should

be retained for treatment but it does say must. These include those requiring skin grafts, bone grafts, revision or amputation stumps, closures of colostomies, neurological procedures, etc., and those with psychoneurosis, severe enough to require hospital treatment. "Chronic neuropsychiatric disturbances will not be retained for definitive treatment." Judging from common practice, it seems that there is a tendency to stop reading at this point. Let the Committee invite your attention to subparagraph 1c (7) below, which states, "When the individual is to be separated from the service on Certificate of Disability for Discharge, irrespective of line of duty status, and further hospitalization is necessary, he will be transferred to a Veterans Administration hospital, State or other institution, and there discharged." The common practice seems to be to let this subparagraph apply only to neuropsychiatric cases. Again, there is a reluctance on the part of soldiers to leave the Army hospitals in favor of Veterans Administration facilities. This subparagraph is stressed as a means already established, by which hospital commanders can clear the decks of chronic and undesirables who are occupying our much needed beds, during this period of emergency; exceptions to be made only for important teaching material.

During FY 1948 the ZI hospitals disposed by CDD 15,230 cases - 12,303 from general hospitals, 2,927 from station hospitals. The deduction is not too exaggerated to infer that over 100,000 bed-days could have been saved by earlier transfers to Veterans Administration.

Using all these means covered above, it is estimated that we could easily clear 2,000 or 3,000 beds in the Army in the near future, which would be equivalent to a new general hospital. At this time when the SGO staff is doing everything to establish nearly 25,000 additional beds, this action should be taken seriously. Besides it is economically sound, since it will cost the Medical Department over a thousand dollars per bed to reconstruct and equip these new hospitals, not even considering the cost of personnel and maintenance. A reconditioned general hospital, using existing temporary buildings, will cost us over one million dollars each.

The Committee, therefore recommends the motto, "Get Rid of the Patient," or in the plumber's vernacular, "Keep Your Drains Open."

Now there are a few other topics worthy of mentioning for consideration:

Internal Reports.- Some general hospitals have found it advantageous to require monthly or at least periodic reports from their Registrar or Chiefs of Professional Services, carrying the number on each service, section or ward of patients who have been in the hospital three months or longer, or some other specified time. A mimeographed form is useful to be made out by each ward officer showing: Column (1) Those patients by name; Column (2) Short diagnosis; Column (3) Prognosis; Column (4) Probable disposition as to duty, CDD or AUB and the month in which they anticipate separating the patient. This is recommended for those hospi-

tals which do not already use it, for it gives the commanding officer some definite information on which to stimulate their dispositions.

Employment of Patients.- The conservation of personnel could again be facilitated by the employment of patients as still provided in paragraph 2b, AR 40-590, which reads: "By order of the commanding officer of the hospital and under direction of the commander of the detachment of patients, convalescent patients may be employed to perform such light duty in and about the hospital as may be of therapeutic value or which may tend to improve their physical condition." It is realized that this is difficult to re-enforce after the laxity of war. Disciplinary problems may arise which are greater than the value received, but their employment is legal and certainly worthy of reconsidering.

Disposition of inapt officers and men.- One standard means of implementing conservation is to improve quality. Hence every effort should be made in this early stage to get rid of the inapt officer and enlisted man. The former can be separated as surplus; the latter by the AR 615-368 or 369 Boards.

Enlisted staff vs. civilian employees.- During the past three years our general hospitals have undergone two or more complete cycles of policies in regard to staffing with enlisted technicians or civilian employees: (1) At the end of the war we had a high percentage of civilians; (2) As the men came back from overseas, they replaced them; (3) As enlisted men became discharged, civilians again had to be hired; (4) Then funds were cut and enlisted men again took over the jobs; (5) Later the Army decreased in strength and civilians once more were allowed; (6) Presently, with influx from draft, we anticipate enlisted men again. This turnover and instability has been costly in administrative overhead and especially in technical proficiency. While labor markets vary with localities, it is suggested that a policy of 50-50 ratio be adopted. A high-grade permanent civilian technical staff would give us stability and teachers; the enlisted men would compensate for civilian 40-hour week handicaps and furnish a cadre for overseas replacements or a national emergency.

Medical Service Corps Officers.- We are of the opinion that more MSC officers can be utilized in our general hospitals as replacements for our professional officers. Every effort should be made to obtain them. We are just beginning to rely on the substitutions so far made and believe that their efforts should be extended into many more fields so long as quality is obtained.

Nurses - Property Account.- Now that nurses have been commissioned as officers in the Regular Army, it is only proper that they should assume their responsibilities along with their privileges. In most civilian hospitals the nurses are required to assume the responsibility of property on their ward, clinic or department. There seems to be no legal reason why they could not do so now in our Army hospitals. Consideration might be given to their employment in these capacities. How-

over, it is realized that we will be terribly short of nurses as well as doctors.

Active duty for Retired Medical Corps Officers.- Without taking exception to the existing laws regarding retirement, it is urged that in this national emergency every effort be made to offer these retired officers, who are capable, an opportunity to return to active duty. It is believed that there are many positions they could fill in a commendable manner.

Contract Surgeons vs. Civilian Employees.- We all realize that when a contract surgeon's job gets to a certain point, that you can no longer obtain, for the pay offered, the quality of physician required. Efforts should be made to increase this pay by some means and/or get the jobs on a non-Civil Service employment basis. The idea should be explored that there may be some very fine older doctors who would be willing to serve full time in this emergency who cannot pass the physical.

Statistics - Operating Personnel and Cost Accounting. - Those presently issued by SGO are so modified by footnotes as to make them worthless for comparative interpretation. It is recommended that the data be obtained on a firm basis, equal to all general hospitals.

Army Regulations.- A review of the 40-series of Army Regulations reveals that many of them are five to twenty-some years old. Many of the others were written during the time of the Army Service Force and Service Commands. Most of them have been modified in one way or another by War Department Circulars or other official documents. It is desirable that various directives be consolidated and that new concepts be crystallized by early revision of these regulations. TM 8-262 was a splendid idea, but it is incomplete and seems to have been abandoned. It should be revised and completed.

Physical Examinations.- One of the missions of the Medical Department is to conduct physical examinations for applicants for the service, Annual Physical Examinations, and a host of physical examinations for civilians as provided in Par. 6, AR 40-505. The load on some of our institutions is tremendous and it is recommended that the SGO review all of the authorities which require this done. Particular attention should be given to the examination of applicants for Civil Service jobs, especially those of military posts having large numbers engaged in production, such as arsenals. The feasibility of contract surgeons for this job, in addition to our medical staff, should be thoroughly explored.

Veterans cases in Army hospitals.- The SGO authorized patient capacity at general hospitals by specialties as of 30 June 1948, reflects that 3,035 beds have been allocated for Veterans Administration patients (See SGO Press Release, 8 July). While some of these could be continued at certain hospitals, it is questionable how some like Tilton General Hospital can do so and perform the mission of the increased expansion planned for them. It is estimated that these 3,000 beds would require

150 doctors and it is not understood how, in this emergency or until the draft of doctors is consummated, we can afford to continue this load. It is realized that commitments have been made, but it is felt that in this existing emergency that these commitments should be reconsidered.

Housing.- Besides the above points on staff administration and conservation of personnel, the Committee would like to propose that extreme efforts be devoted to providing housing at our general hospitals. When doctors leave medical school, their average age is about 26. They have several aims in life: For example, (1) To practice their profession in a successful manner; (2) To get married and establish a family: (3) To have security; and (4) To have a home. The Medical Department is in an enviable position to offer facilities for the practice of their profession in the manner they desire. While their salary is not adequate they at least have security. The one thing we need most to furnish as an incentive to bring doctors into the Army is housing. This offer is not so true at non-medical posts, because their rank will usually entitle them to some acceptable quarters. However, at general hospitals, the condition is generally deplorable. It seems so unnecessary too, when it is so economically feasible to furnish these quarters. The average Army house now costs between $10,000 and $20,000, depending upon size, let's say an average of $15,000. To occupy the house the officer gives up about $1,500 per year. In 10 years he pays for the house the government has built and owns, which house, under modern specifications, will last at least 50 years. This one aspect of the problem in procurement of medical officers should again be presented to Congress in a most emphatic method possible. We know that the Bureau of the Budget and Congress have generally been opposed to revolving funds, but if the Army were allowed to use the commutations deducted and build more quarters, it would be a very few years before the Army was adequately and entirely housed and thus an equal number would be available for civilians.

General Bliss, your Committee is aware that they have not covered all subjects pertinent to the problem, nor any question completely. Time does not permit. However, we trust that this brief may stimulate discussion and start some chain reactions. We regret that we cannot come out with an approved and total solution from within our Medical Department but the demands are too great. To fulfill the Medical Department's mission, we conclude that the only adequate solution is to draft doctors. The situation is not only our crisis; it is a National Emergency. The civilian medical profession, and the nation at large, must be made to realize that this is so.

FOR THE COMMITTEE:

/s/ CVMorgan

CLIFFORD V. MORGAN
Colonel, Med Corps
Recorder

DISCUSSION ON PERSONNEL

GENERAL ARMSTRONG:

Now as to the matter of training: You gathered from Colonel Robinson's remarks this morning that the Army Area and Air Command were heartily against this plan. I think there will not be so much opposition if you can get them to carry more of the Service. You will eliminate criticism of the training program if you can get the residents to carry their load. There are certain things we feel that can be curtailed. In the first place, I believe there are men in the training program that can just as well be gotten out and put in a C or D rating, men who will never reach the top, never take their Boards. We think the Educational Committees in the teaching hospitals should very carefully look them over and see if any individuals are wasting themselves in the program. Some hospitals have done this and have gotten word back that Joe Doaks will continue in the program. Now, there may be some good reason for this, but I believe this office should look into it. Take another group: The Boards have changed their requirements as to the amount of formal training necessary to take the Board examinations. There may be men in the program now who do not need any additional formal training, and those are needed in new hospitals. Another policy we are going to pursue is that it will be very rare during this critical period that a Regular Army doctor with five years or more of service will be put into the program unless he has had a commitment already. As far as civilian training is concerned, there has been a lot of criticism about the number of people going into civilian training. That, too, is going to be cut down to the minimum - sending them out for training where it can be done in the Army.

COLONEL ROBINSON:

I think maybe I may have misled you. Not all of the procurement we are doing is for the training program. That is not exactly right. We have 44 doctors and out of that only two are going into the residency program. Only 25% are on duty. We are actually making some demands. Of the 44, 42 will be working people.

GENERAL OFFUTT:

You say that no officer in the Regular Army with over five years of service will be taken for the residency program at the present?

GENERAL ARMSTRONG:

That's right.

GENERAL OFFUTT:

Does that five years include constructive work?

GENERAL ARMSTRONG:

I am thinking of a man who has been out of his internship for five years. For the past year, men have gone in with 5 to 15 years of service. We have actually put men in around 40. In some of these cases it was either that or lose the man, but during this critical period we feel is no time to put the older men in.

GENERAL BEACH:

I think normally those people now going in for residency training should be selected from the interns we have in the service now because if we are going to train a man to be a specialist we should start in his internship. In about a year or so we will have it completed except for the very new coming in the Army. Another thing we will have is graduation of our interns. We have 27 interns reporting the first of July. These 27 next July will make application for the Army provided they can have a residency. Are we going to give all those men a residency? I don't believe we will be able to do it. That is going to happen in every general hospital. I think 95% of the interns will stay in the Army if they can have a residency for the next three years, but the Army isn't going to be able to do it. We should be able to take a good percentage, but not over 50% or 60% at most. The rest may be selected for a residency after a year's duty in the field. We are going to lose men that way.

GENERAL OFFUTT:

We also have another proposition coming up. Men overseas have applied for the Regular Army because we have assured them they will have an open shot for a residency. Some of them will have had over 5 years of constructive work.

GENERAL BEACH:

I think it is a mistake to take anyone over 35 for a residency.

COLONEL ROBINSON:

As a matter of fact, most of these older men are already in a residency program. There are only 10 who have been deferred for one reason or another who are desirous of getting into a residency program.

GENERAL OFFUTT:

Some men overseas have been more or less assured that they would have a chance, and I think you are breaking faith with them if you don't give it to them.

COLONEL ROBINSON:

We have no intention of not carrying out what we have obligated ourselves for, and we think we can do it in civilian hospitals too, giving a residency in 1950 or 1951 and give him a certificate to that effect.

COLONEL AMSPACHER:

If we promise a man one in 1953, he will get it, because unless an opening is there we would not tell them so.

COLONEL ROBINSON:

I think that will help straighten out part of the problem.

GENERAL OFFUTT:

If you can assure a man that eventually he will get it, you will hold more of them.

GENERAL BEACH:

I don't think you will. I can't see how you can build up a corps of specialists in the Medical Corps. We will have to have some doctors and general practitioners. We will have to sell the younger men on being general practitioners and not just specialists. At least half should be the common, ordinary variety of doctor that could go out on a post and do anything, deliver a baby, take out an appendix, etc. If you could interest some in a residency as a general practitioner that would not lead to a Board.

GENERAL WILLIS:

I agree with General Beach. We are going to have too many specialists. I also agree with him on the 35-year age limit. A great many of the older residents you speak of have had 1 or possibly 2 years and are interested in changing from one residency to another because they have a good assignment, good quarters, etc. That is the group

so badly needed at the larger station hospitals, with camps opening up.

COLONEL ROBINSON:

We have established at Madigan on a small scale the clinic physician.

COLONEL GREEN:

How many have applied?

COLONEL ROBINSON:

It hasn't been a problem at all - only about 15 applications!

COLONEL GATES:

Is it appropriate for a man after he goes in on general surgery, if the individual shows a desire to continue the specialty, to stay in one type?

COLONEL ROBINSON:

I believe that is a good idea.

COLONEL LEHMAN:

Have you given any thought to being a little less rigid on the requirements from a physical standpoint? A good many, for instance, are a little myopic and cannot make the 20/100 requirement. It might be worth while considering a waiver for between 21/100 and 22/100.

COLONEL MUDGETT:

I think we are accepting those individuals. I believe it is done up to 22/100.

GENERAL BEACH:

I would like to ask if anyone has any idea as to how we are going to interest these younger men coming in to be doctors and not specialists. It is the same thing in civilian life. Before long we will have

to wake up to the fact that everyone can't be a specialist. They should constitute somewhere between 25% and 35% of the Regular Army Medical Corps.

COLONEL ROBINSON:

Our books are set up so only 26% of the Corps will be specialists. We have not had to face that problem yet.

GENERAL BEACH:

What are we going to do with those men who will come in if they can be a specialist and then when they get through they get out of the Army? I don't think we should promise them so much, and I believe we should put them in a position where they can't doublecross us so much. I think a man should have to sign up for three years after he gets his Board. Civilian Boards aren't going to like it either.

COLONEL LEHMAN:

I think so, too. I agree.

GENERAL OFFUTT:

I think the basic difficulty goes back to the medical educational system. We start talking "Board" right from the beginning.

COLONEL GATES:

How about the dental part? No outside help is being considered. There is no program on that.

COLONEL ROBINSON:

You mean, getting work done by civilian dentists? On military personnel, if you don't have enough dentists to do the work for the military you can get it done by a civilian dentist on a fee basis. That has been in regulations for some time.

COLONEL MEYER:

How about dependents? We had 644 patients in July and over 400 were dependents. For a town of 130,000 there are only 530 doctors.

COLONEL ROBINSON:

On the dependent problem, you heard what General Bliss had to say, which corresponds with General Bradley's views; however, on out-patient calls and elective work, curtailment is being made. A directive will be issued on this.

COLONEL SOPER:

At Tilton we have authorized 275 veterans' beds. Those cases require more personnel in the way of professional nursing and Medical Department care than any other 600 patients in the hospital, and not one has a service-connected disability. We have cardiacs, malignancies, etc., requiring extensive surgery, multiple blood transfusions, requiring special nurses and special corpsmen. They present the greatest disciplinary problem and the greatest financial outlay.

GENERAL ARMSTRONG:

I am going to state that Colonel Schwichtenberg, who is just back from the Far East, is going to go into this very carefully. The first reaction might be very unfavorable in asking Veterans' to take back their 3,035 beds we now have allocated. In the first place, there are two groups we don't want to give up. The first is in the teaching hospitals. You get cases in under that bed allotment which are valuable for that purpose. The second group are in hospitals like Puerto Rico, Guam, Honolulu, and like Fitzsimmons, where we are furnishing beds to keep the Veterans' Administration from constructing hospitals. Whether we will ask them to take back beds such as like at Tilton will be studied. We are also making quite a study of places where we may want to ask them to give us beds. We don't want to have Army patients in VA hospitals if we can help it, but in a few places we can save construction of a hospital By so doing we may obviate being told to do it, also!

COLONEL SOPER:

You are right about the value of them for teaching purposes.

GENERAL ARMSTRONG:

Actually there are 667 beds like that which we could give up without interfering with teaching.

COLONEL WELCH:

One type is geriatrics. If they once get in, you can't get rid of them. They are no use for teaching purposes.

GENERAL OFFUTT:

Soldiers' Home cases, that's what it amounts to.

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ROUND TABLE DISCUSSION ON SPECIAL COMMITTEE REPORT

GENERAL ARMSTRONG:

Before starting the discussion, I would like to thank Colonel Morgan, Colonel Clark and Colonel Stanely. I feel that their report is a very fine contribution, and I want it reproduced so each of you can have a copy right away and won't have to wait until you get the minutes of the whole meeting.

COLONEL LEHMAN:

I believe the amount of clinical material that our hospitals get in the care of veteran patients is too important to consider asking the Veterans' Administration to take them away. I do feel, however, we might ask VA for a certain amount of professional help in a ratio per bed, say of 1 to 30.

GENERAL ARMSTRONG:

I believe that point is one worth exploring.

COLONEL MORGAN:

I would like to say that in a lot of the smaller hospitals it would not make much difference, but it certainly would in the cases of Tilton and Fitzsimons. I question very much if you get a thousand or fifteen hundred tuberculous patients, for instance, whether 700 or more will give you any more value in the way of teaching material.

GENERAL STREIT:

It would apply at Brooke. The 400 beds we have for veterans constitute our most valuable types for teaching purposes - the cardio-vascular-renal cases, malignancies, degenerative old age diseases, and innumberable acute accidents we take care of, all of which are an important part of our teaching program. One point in your recommendations which I don't agree with and would like to comment on is with reference to transfer of officer patients to a number of general hospitals where they would be disposed of by Retiring Boards. The recommendations said

they should be worked up completely before transfer. It has been my experience that no professional group will accept the recommendations of any other hospital, so these men, no matter how completely the patient had been worked up, would want to work him up again, and I think it would be much better to have the staffs make up their minds whether or not they have a Retiring Board case and then transfer immediately.

COLONEL MORGAN:

The committee feels that if this were true the Retiring Board hospitals would really get an influx. I don't see any reason why one hospital would not accept another's statistics. Certainly, after the patient has met a Disposition Board, the fellow who is the medical witness for the Retiring Board is not always the fellow who worked the case up. He has to take the records. When the case gets to The Surgeon General's Office they have to make their decision on the records, and they don't see the body! I don't see why, if the records are any good, that they wouldn't be accepted.

GENERAL BEACH:

We find, even at Walter Reed where the case is worked up right there for the Retiring Board, that very often the witnesses have not known anything about the case until it has gone through the Disposition Board and in turn they come in and look the man over and there are lots of things they want done, right in their own hospital. This has happened so much that we now require the medical witnesses on a case coming up before the Disposition Board to sit in with the Disposition Board so they know all of the reasons why the Disposition Board has come to their conclusion, and now, so far as the medical witnesses are concerned, they can take the man up before the Army Retiring Board the day after he meets the Disposition Board. I think your point is a good one, because I believe you will certainly have trouble with one hospital accepting the word of another one, and then, too, the man will have time to read his record, which they send along with him. He has then developed a lot of new complaints. If he wants to be retired and they haven't recommended him for retirement, he will show up with a lot of new complaints.

GENERAL STREIT:

In that way the case appearing before the ARB would have the stamp of approval of examinations at that particular hospital, and the staff at that hospital would not be responsible for those recommendations and finds without having verified them.

COLONEL MORGAN:

Perhaps the committee did not make itself very clear. It was not

intended to deprive the hospital receiving the patient from doing anything they wanted to. It was to prevent the hospital from sending you 100 cases at a time instead of perhaps 10.

COLONEL MEYER:

I don't believe they would do that. They would only send those cases they felt were going to come before an ARB.

COLONEL LEHMAN:

The chief objection to having more than one Disposition Board proceedings on a case coming up before the ARB was stated by General Beach when he said the patient was given a transcript of his Disposition Board and if there is a difference between the recommendations of the two hospital Disposition Boards, then the next step may well be The Surgeon General's Office.

GENERAL OFFUTT:

You will have disagreements on a certain number of borderline cases anyway that you will have to bring up before an ARB.

COLONEL MORGAN:

I judge the argument then is not to have the Disposition Board before hand, but just send the case in.

COLONEL LEHMAN:

On a case coming up for retirement, after we get the case and the other hospital's Disposition Board has recommended retirement and we disagree, that man has grounds for complaint, and he will take full advantage, and the next stop will be the Surgeon General's Office. Letterman says he should be retired and Army and Navy says he should not. The worst complaints I have had were between Disposition Boards.

COLONEL MORGAN:

That's happening all the time. One hundred ninety-eight cases were sent back for review last year and sent to another hospital.

GENERAL WILLIS:

The principal complaint from the officer when he is not satisfied

with the action of a Retiring Board is the fact the witnesses were not the ones who worked up his case, and that observation is made from experience as a member of an ARB and an administration standpoint at Brooke.

COLONEL ROBERTS:

That's true.

GENERAL WILLIS:

We try to have the ward officer be the man's witness.

GENERAL BEACH:

I would like to modify my remarks because I believe I am plagued by the fact I am afraid Murphy and Tilton and Valley Forge or maybe some of the hospitals down South would begin sending all their retirement cases to Walter Reed, and Walter Reed cannot absorb any more. The ARB could, but we can't. We could not have any more in there without delaying their work-up. It would take just as long if they came to Walter Reed as if they stayed where they were. If things straighten out, we could possibly take more. We have 150 cases now being worked up for retirement. The ARB could take more. We have double ARB's, taking 6 a day, but I don't see how we could house any more there. I don't know what disposition you would make about sending them to Walter Reed, but I assume one would be at Walter Reed, which means we would immediately have retirement cases from 3 or 4 other hospitals, and I just don't see how we could absorb them. That probably is my main objection. It might work where you did not already have the hospital overloaded.

COLONEL LEHMAN:

We don't have enough to put any great burden on us. I would like to continue handling the arthritic cases. We have gotten used to them, have gained specialty training. We have both Patterson and Davidson, who have been to Mayo.

GENERAL BEACH:

I think the cases you have should be disposed of at your hospital, because they are specialized cases.

COLONEL LEHMAN:

As long as we head our own Board and have our own witnesses.

COLONEL SOPER:

The Retiring Board at Fort Dix never runs over 4 or 5 cases a week. At the same time there are quite a number of officers in the hospital awaiting action of the Retiring Board. I have tried to expedite these cases through the hospital, but I can't seem to get more than 4 or 5 in any one week. Last week we only had 2. It seems a waste.

GENERAL STREIT:

At Brooke in 1946 we had 1100 cases appear before the ARB and in 1947, 1260. In 1948 for the first six months we have had less than 200. There has been a very sharp drop in cases appearing before the ARB, and we at Brooke can take on an additional 200 to 300 cases per year without overtaxing our officer facilities or Retiring Board personnel. I believe that, with few exceptions, it would not be a problem for specialized cases to appear before Retiring Boards at a limited number of hospitals. We do have specialists. Our general hospitals as a rule handle most types of cases.

COLONEL MORGAN:

Our mission was to find ways of conserving personnel. How many people do you have overhead at Army and Navy?

COLONEL LEHMAN:

We don't have any.

GENERAL STREIT:

We don't at Brooke either.

COLONEL LEHMAN:

It takes a little time, but we have no overhead, that is, people definitely assigned to the Retiring Board alone.

GENERAL PEACH:

I think Walter Reed is the only place we have a Retiring Board full time and with that the only duty.

GENERAL OFFUTT:

I think that along the line of your discussion you could save a great many hospital days if you could speed up the AG in returning papers when asked for. You ask for a man's record and it takes the AG three weeks to 30 days to get it to you.

COLONEL MORGAN:

We did discuss with AG that point. Colonel Hooper has promised to look into it. You used to be able to write in in advance when you anticipated the man would meet an ARB. Now, they say they have to have the Disposition Board first.

GENERAL OFFUTT:

Well, it takes from 3 weeks to 1 month to get records.

COLONEL HARTFORD:

Is there any reason the records could not be asked for a little sooner?

GENERAL OFFUTT:

They will not give them to you until the Disposition Board has been held. During the war there was authorization for you to get the papers as soon as you anticipated the man would meet an ARB.

GENERAL STREIT:

Are you talking about the Regular Army?

GENERAL OFFUTT:

No.

GENERAL STREIT:

Well, unless it has been changed within the last three weeks.....

COLONEL STANLEY (interrupting):

That's just it. It has been changed within the last three weeks and

that is the point of the whole debate.

COLONEL HARTFORD:

We can get them here, but I guess out in the field it's different.

GENERAL BEACH:

A lot they have to get from St. Louis.

COLONEL HARTFORD:

I don't know of any case like this.

COLONEL STANLEY:

That's the clinical records that come from St. Louis. It's the 201 file which the AG has.

GENERAL ARMSTRONG:

May I introduce a new subject and one which, as I remember, was not touched upon in your document? We are having to continually defend the length of stay in Class II installations of the so-called "station hospital type of patient." The Air Force medical people, in conjunction with our Statistic Section, made a study of that some time ago on the number of patients we consider the station hospital type of patient, that is, hemorrhoids, appendectomies, herniorrhaphies, etc. If I am not mistaken, they found that in general this type of case required four times the length of stay if performed in a general hospital as if performed in an AF station hospital, an average of 8 days, and in general hospitals, 30 days. I realize that in many of these instances that may be a part of a general picture which is not betrayed in the statistical picture in this office. On the other hand, and I am a product of the general hospital group professionally, so I think I can speak fittingly on the subject, we who are accustomed to service in general hospitals get in the habit of thinking of all patients as the general hospital type, so when a patient comes in for something like removal of a hemorrhoid the tendency is to do a lot of laboratory work, just as on the general hospital type, on the bare possibility that the patient is going to come before a Disposition Board and you are going to have to get it any way so why not start the day he enters the hospital. I plead with you to try to think how you can inculcate into your hospital staff ways of getting the station hospital type out. It is not particularly a problem at Madigan where the percentage of station hospital type is not very high. It will be true of Oliver when they take Camp Gordon under their wing and therefore the commanding officer, hospital inspector, or someone

should push to get these men back to duty.

COLONEL MORGAN:

We don't have many of that type but Colonel Stanley has about 36% at Oliver. I would like to refer that to him.

COLONEL STANLEY:

I think General Armstrong has given us pretty much the solution. There is something I might add, which occurs. We have an enormous number of the station hospital type of AF men sent in. An illustration is the garrison prisoner. Prior to putting them before a court they send them in for a neuropsychiatric consultation. Well, when they bring that man in (they fly him in) the guard will check him in, then get on the plane and leave. It may take three weeks to get a guard to come after him. In 98 out of 100 cases it only takes only a common doctor to tell that the man is sufficiently capable of knowing right from wrong, so I hold the plane, hold the M.P. on it, give him a certificate, and send the man back out on the plane. There is another problem - the neer-do-well - they will send him in and we can't get rid of him because the commanding officer will immediately write and say he doesn't want him back. We have to go all the way to the Chief of Staff of the Air Force to get him reassigned. We have no Air Force Liaison Officer. Other than that, the rest, as you stated, is up to the hospital commander to to get behind his staff and get rid of them.

COLONEL MORGAN:

In discussing that it was mentioned that perhaps the hospital should have something on the 55-A to designate whether the patient was the station hospital type or Detachment of Patients type; in other words, the station hospital type could be tagged so that he would be expedited through the mill.

GENERAL OFFUTT:

I would like to ask if in your statistics there was any separation made between the station hospital type case transferred and the ones that come in direct?

COLONEL MORGAN:

No.

GENERAL OFFUTT:

We have an enormous amount of transfers from Air Force and elsewhere which are transferred through to our Detachment of Patients. They come in as part of Detachment of Patients, and you can't get rid of them in a few days. They have to go through the whole chain.

GENERAL ARMSTRONG:

That may be the answer to the statistical data.

COLONEL MEYER:

We take care of all of the air fields in Arizona and New Mexico. We have the same trouble. No admission is authorized. They will send them down to a clinic. The plane will fly in and dump them, have no orders, and will just go off and leave them. We have a terrible time. Every case they transfer to the Detachment of Patients and once you get them you can't get rid of them.

COLONEL STANLEY:

I might tell you a little secret. I established the custom of sending these orders back to the man who issued them, pointing out we did not recognize their authority to transfer to our Detachment of Patients.

COLONEL MORGAN:

One solution might be for your staff to follow up with the Air Force staff the same as with the Army staff, and that is, to dump them on the closest post and let them get the assignment.

GENERAL OFFUTT:

We had quite a problem early in the emergency before this last war in trying to unload the general hospitals, and I fought with G-1 and G-4 constantly for months trying to get established centers at which patients ready for duty could be unloaded. The best solution we could get then was that finally they authorized the service commands to set up such centers and eventually all of the service commands did set up some center to which hospitals in their area were authorized to return patients who were ready for duty. It was taking a month to six weeks to get orders. Now, if we could establish something like that.

COLONEL SCHLICHTENBERG:

I have just come back from the Far East where the problems are a great

deal different. My thought is to take this up right away with the Air surgeons and Air staff and work out a more intelligent and rapid solution to the problem than we now have.

COLONEL ROBERTS:

I would like to ask one question. Most of you know that 4 or 5 days ago an order came out that no Army installation could discharge any Air Force man. Now, if hospitals can't discharge patients, whether Air Force or not, what is the solution?

GENERAL ARMSTRONG:

General Hargreaves and I were discussing that. I don't know whether it will be possible to give you a solution before the end of this conference. We will try. If not, you will get it as soon as possible. It will have to be a modification of that; otherwise, we cannot continue.

GENERAL STREIT:

I would like to say just a word in commendation of the Air Force. We lost our Liaison Officer a few weeks ago, and prior to his departure the Air Force patients at that time were handled more expediously than the Army, so far as getting orders was concerned and arranging for their departure, and at Brooke today we are having less trouble than with the Army, so far as getting orders.

COLONEL ROBERTS:

I believe if we could get authority to send all these patients who have completed their treatment and are awaiting orders to the nearest Air Force field or station we could save several thousand hospital days per year.

COLONEL HARTFORD:

I think the question of dependent care came up, and I would like to give you the status of that to date. Insofar as dental care is concerned, the proposed circular states that dental care will be given to active duty military personnel only. Insofar as medical care is concerned, we are only justifying the situation which occurs out in the field. In this proposed circular we require the commanding officer of the installations having medical facilities to conduct a survey to determine the maximum amount of dependent care they can render and then publish it to the command.

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There followed an off-the-record discussion, and then the meeting adjourned for the day.

Morning of 5 August 1948

COLONEL MUDGETT:-General remarks on physical standards.

The final plans for the induction, and physical examination of military personnel under the Selective Service Act of 1948 have not as yet been formulated. The present tentative plan is ready, however. All persons inducted through the Selective Service System will be channeled through Joint (Army, Navy and Air Force) Examining and Inductions Stations. Army-Air Force Recruiting Main Stations will serve as Joint Examining and Induction Stations, in addition to their present voluntary enlistment function for the Army and Air Force. Use of these stations for joint induction will eliminate the need for a new organization requiring additional installations and military personnel; in addition, these stations already provide a network which blankets the country; thus affording practical distribution of the expected workload and minimizing travel required by examinees. Army and Air Force personnel have already been allotted to operate these installations, and the Navy will provide personnel to be attached to each station at such time as the Navy and Marine Corps commence accepting inductees.

The Commanding Generals of Armies (Zone of the Interior) will continue to be responsible for all Joint Induction Stations within their respective areas, and for effecting coordination with the State Directors of Selective Service. Immediate supervision of these stations will continue to be exercised through the Army Recruiting District Headquarters. It is tentatively planned to increase the present number of Main Recruiting Stations to a total of approximately 288 for the country as a whole. Under the present tentative plan, the number of persons examined each day will average 10-20 per day at each station, and this number would include those examined and rejected.

Present plans call for the screening of inductees at the local board level and the elimination of the obviously unfit, thus tending to lighten the load at the Joint Examining and Induction Stations. The pre-induction physical examination will be done at the Joint Examining and Induction Stations. The examination will be a complete mental and physical examination, including physical profiling. After this the registrant will return to his home for from three weeks to 120 days. The latter limit is set to insure the validity of the physical examination, and preclude the necessity of repeating the examination at the time of actual induction. Individuals, including suspected malingerers, whose physical status cannot be definitely determined at the Joint Induction Station will be ordered to Army or other service hospitals, designated by Army Commanders, to establish their status, prior to their return home to await induction. In this connection, general hospitals may be called upon to assist in the determination of certain Registrants' fitness for induction.

Present plans call for the use of civilian physicians on a fee basis

as provided for in Department of the Army Circular No. 58, Air Force Letter No. 25-8, dated 5 March 1948, for the actual conduct of the physical examination. The x-ray examination of the chest is to be made at military installations wherever the facilities exist, and the same is true for the serological examination. General hospital x-ray and laboratories may be called upon by Army Commanders to assist in completing this part of the examination, in certain areas. At other places where military or other service or Federal facilities do not exist, local civilian facilities for the completion of x-ray and serological tests may be used. The responsibility for this phase is the Army commanders. Fees for x-rays vary from 50 cents in certain areas, to $11.75 in Miami. Some limitation on these fees is currently being studied by the Fiscal Division, SGO. It has been estimated however, that for a complete examination including x-ray and serology would cost on an average of $10.00 per examination, if done by entirely civilian sources. With the use of all available service and Federal facilities for x-ray and serological tests this estimate can be materially reduced, and facilities wherever conveniently located must necessarily be used. This may be an added load for a few of the general hospitals in locations where no other service facilities exist.

The revised Mobilization Regulations No. 1-9 (now being redesignated as AR 40-115, entitled "Physical Standards and Physical Profiling for Enlistment and Induction), Department of the Army (1948) is to be used at Joint Induction Stations as the universal method of physical examination, and as the uniform physical standards for the induction of personnel into the Armed Services, and for physical profiling. New standard physical examination Forms 88 and 89, revised to include certain Selective Service data will be used for the physical examination report and the report of medical history. It is probable that the standards for acceptance will include for general and limited service. In the new regulation, the terms "general and limited service" are not being used. Instead, certain levels of physical fitness are designated as physical profile serials 1, 2, 3 and 4. It is probable that induction will include some #3 profiles, except with suffixes R and T, which means that those with remedial, or temporarily disqualifying defects will not be immediately inducted, and will be deferred until correction of defects has been accomplished. This should lessen the number of the individuals who might require hospitalization and treatment soon after induction. The final determination of acceptance on a physical fitness basis has not as yet been made.

On 2 August, instructions were issued by Forrestal regarding Medical discharges. No person, whether enlisted or inducted, will be discharged for medical reasons by any military department, during the life of the Selective Service Act, if his reclassified physical profile serial is at the minimum or higher than the minimum profile serial acceptable for induction under MR 1-9. No list of specific injuries, diseases or other medical conditions will be established "as cause of discharge for physical disability" and the medical evaluation (physical profile serial) of the person's physical capacity will be determining for discharge in the same manner as for induction. In general, the following joint statement of

policy will govern: to wit, an individual shall be discharged from the Armed Services for medical reasons only:

a. When in the judgment and opinion of competent medical personnel he has become functionally incapable of performing useful duty during the remainder of his service with due consideration given to whether his scaled-down physical profile serial is consistent with any assignment wherein he could perform useful work within the military department in which he is serving.

b. Or when he has a medical condition of such nature that, in the opinion of competent medical personnel, to retain him for further active duty would aggravate such condition to the detriment of his future health and well-being.

c. Or when his retention would, in the opinion of competent medical personnel, jeopardize the health or safety of his service associates.

I would like to stress again that much of what I have just stated is in the form of tentative planning which has not as yet the final approval of the Secretary for Defense. Definite plans are expected to be issued in the near future. Suffice it to say that the general hospitals will have little to do with the actual examination of Registrants except to assist the Army commanders with their medical facilities when called upon to do so, either by the use of their x-ray and laboratory facilities or the study of selected cases in the hospital to determine their physical fitness for induction at the time of the pre-induction physical examination.

I would like to say a few words about Army and Air Force retiring boards. Recently, as you know, the Air Force has appointed additional officers of the Air Force to comprise Air Force retiring boards to hear retiring board cases at general hospitals, in the case of officers of the Air Force, using the regularly assigned Medical Corps officers of the board, the regularly assigned Recorder. It is not believed the number of these cases will be great at any one hospital. The number of retiring board proceedings reviewed in The Surgeon General's Office for the first six months of the fiscal year, 1948, was 3715, of which 412 or 11% were reconvened boards. The number reviewed in the last six months, ending 30 June 1948, was 1818, of which 198 or 10.8% were reconvened boards. The general trend of the numbers of retiring boards is still downwards, as is the percentage of those which are being returned for re-hearing. It is likely that this will continue, even with the probable increase in the numbers of officers which may be called to extended active duty in connection with the increase in the size of the Army coincident with Selective Service. The number of individuals requesting the Department of the Army to reopen their cases has likewise been reduced about one-half during the past 12 months. These requests are still being received for review at the rate of approximately 200 hundred a month, however.

The Adjutant General is presently issuing instructions to general hospital commanders relative to the care and treatment of former officers returning to general hospitals on a civilian status for re-evaluation of their cases. In this memorandum it is stressed that hospitalization is being authorized only for re-evaluation. It is also stated that it is not contemplated that elective medical and surgical treatment not related to the conditions for which re-evaluation has been authorized will be given.

A committee under the Secretary of Defense has currently been studying the feasibility and desirability of having but one review of retiring board proceedings, in each Department, (that is, Army, Navy or Air Force as the case may be). It has been recommended by this committee that a board of review be set up under each Secretary (Army, Navy, and Air Force to review proceedings in the name of the respective Secretary. If such a procedure is finally adopted, a review of retiring board proceedings in the office of The Surgeon General will be discontinued and will expedite Department of the Army action. A decision in this matter may be forthcoming within the next month. At the present time Army retiring boards are reviewed in the SGO, and by the Army Personnel Board. Air Force Retiring boards are being reviewed by the Air Surgeon's office, the Surgeon General's office, and by the Air Force Personnel Board.

The discontinuance of sick leave following the meeting of the retiring board, while waiting for the action of the Department of the Army or Air Force will be again studied to see if it must be continued Legal opinion. This was considered a necessary decision, by Welfare and Emoluments, AGO, that had to be made in view of Section I, Public Law No. 350, of the 80th Congress. The question as to whether to require an officer to use his accrued leave while waiting for the final decision in his case has also been under discussion. From the standpoint of the hospital commander the desirability of this being required can be understood; however, it has not been the policy of the Army in the past to require any officer to avail himself of his accrued leave. It seemed unwise to insist that he use his accrued leave at a time when his separation from the Army is about to take place, in view of the terminal leave pay act. On 23 July 1948, the Adjutant General dispatched WCL 42723, with which I am sure you are familiar. This authorized commanders of general hospitals with retiring boards to issue orders in the name of the applicable secretary granting leave for any period in excess of number of days leave authorized by Section 1, Public Law 350, 80th Congress, in the case of officers awaiting orders on disability retirement proceedings. This is the authorization for granting leave in excess of accrued leave.

Recently an inquiry was sent the commander of each general hospital, ZI, asking his opinion as to the desirability of concentrating retiring board actions at 4-5 general hospitals. The comments from these inquiries are presently being studied, and a decision in this matter is expected to be made in the near future. The advantages to this procedure seem rather obvious to those who would no longer have retiring boards. The disadvantages to individual patients who would be necessarily transferred comparatively long distances to meet retiring boards is equally obvious. To those hospital

commanders who would continue to have retiring boards, the load of patients meeting retiring boards would be increased about 50% over the present load, in some instances, in all likelihood. If certain retiring boards are discontinued, it would seem that transfer of the patient following completion of his necessary hospital observation and treatment, but prior to meeting a disposition board might be the logical time for such transfer. The receiving hospital should then need to do very little in the way of additional examinations, in order for the case to be presented to the board for a hearing, in most instances. The data from the sending hospital should be used to its fullest extent, without repetition of the clinical studies, except where necessary. On the other hand, it might make for more efficient handling of the case if it were transferred at the time it was determined that retiring board action would eventually be required, and prior to the completion of hospital treatment. The latter may prove to be the more desirable, though some patients might be transferred unnecessarily if this policy were adopted. The use of traveling boards does not seem feasible or desirable.

COLONEL HARTFORD:

Are there any questions you wish to ask Colonel Mudgett?

GENERAL OFFUTT:

I would like to ask a question about the telegram in regard to leave. Am I interpreting that right when I say - If a man has 30 days leave coming and it is going to take him 45 days to get his papers back, you could give him 45 days.

ANSWER:

In the name of the Secretary; that is right.

GENERAL OFFUTT:

You could give him any amount of time--of leave while awaiting retirement?

ANSWER:

Except sick leave; that is right.

COLONEL HARTFORD:

Any other questions?

GENERAL HAYES:

I have a comment on the X-raying of inductees in the interest of economy and also in the interest of conserving X-ray film. Probably most of you know how serious our X-ray film situation has been for the last three years. I would like to urge that photofluorographic equipment be used to the maximum possible extent in this induction work. We have a great deal of that equipment out in the Army Areas now and in the Air Force station also, and some of the General Hospitals also have photofluorographic equipment. So I would like to see that it be used to the fullest extent.

COLONEL HARTFORD:

We will now have some general remarks by COLONEL JOHNSTON.

COLONEL JOHNSTON:- General Remarks on Hospitalization.

General Armstrong and Gentlemen: Since Dependent Care was discussed so well yesterday by Colonel Hartford, I will forego that and take up the other subjects.

First, as you know in Atlantic City last September the weather was very bad and some of the equinoxial storms swept away the board walk, and all sorts of things happened.

Letters of invitation went out to the Hospital Commands for the AHA Convention at Atlantic City. At the time these letters went out it was preliminarily checked, supposedly, and funds were found available so that we could invite one and possibly two to go as our guests to the Hospital Convention. However, when everybody accepted, we thought we had better run a re-check to make sure, and we found that funds were not available.

Last year (FY 1948) The Surgeon General had about $7,000 in funds available to send Army Officers to civilian meetings. This fiscal year we have less than that. Our grandiose program as we had planned it, would have used about $3,300 of the $7,000, so that something had to be done; and a decision was made that those officers who were closer to Atlantic City, and those who had a shorter period of command experience in the General Hospitals should be given the chance to go to Atlantic City.

This is the way it is set up now-- and we will get out the instructions later to those who will attend. If anybody is in doubt as to whether they are going or not, I will be glad to let them know.

Mr. Royall, Secretary of the Army, has instructed the Inspector General to make a survey of the TROOP INFORMATION AND EDUCATION PROGRAM.

Apparently, there have been a few suggestions for improving the Service or deleting certain portions of it and adding certain parts which might be better. At any rate, The Surgeon General has been instructed to survey the Class II installations in regard to the Troop Information and Education Program. We are getting out some letters. They are being typed now, and we will get them to you by this afternoon; they give you the various forms which will have to be filled out--the necessary forms--or we wouldn't send them to you. On a few of the letters is the expression: "Reply not later than the 23d of August". This is very poor staff work. However, in their zealousness to get these letters out, they put that expression in the first few letters. So, anybody who gets a letter with that on it, please ignore it; because we know if we have to have certain information by such and such a date, we will have your cooperation.

The last matter which I have to take up is one which took the Hospital Division by surprise. It was first brought to our attention by General Beach out at WALTER REED and Colonel Stanley down at OLIVER. It concerns Public Law 755 of the 80th Congress, passed in the closing days of the pre-comback session and it was approved the 25th of June.

This law, which I am sure you are all familiar with now, in effect, prohibits the General Hospital Commander or any Army Hospital Commander from having Courts Martial jurisdiction over any Air Force patients in his detachment of patients. Assembling the legal minds and all the research people we tried to look into the background a little bit. We find the Army is entirely at fault, and I don't say that in a derogatory manner. Research shows that the Air Force JAGD initiated the law with the reciprocal phrase in there which would have made the Army patient in the Air Force Hospitals under the jurisdiction of the Air Force Command, and vice-versa, which would have straightened out everything. However, when it came to the JAG of the Army the "vice-versa" phrase was red-lined.

The Surgeon General, so far as I can find, was never consulted. He never saw it until it came out in the Public Law, then we received Colonel Stanley's and General Beach's letter relative to the law, the same day. This is presently under study and we expect something to come out as soon as we get the wheels to turn and bring it out. In the meantime, we will have to look for an interim measure. One of the ones that has been suggested is that we treat these Air Force patients, in the detachment of patients, the same way we do the Navy patients in the Army Hospitals and refer either the charge-sheet or a letter of transmittal explaining what has happened to the nearest Air Force installation. Walter Reed does that with the Navy patients now. I presume that is done throughout; I don't know.

We are now implementing one of the first HAILEY BOARD recommendations down in the Portsmouth Area by sending Army patients who require general hospital type care that the Navy can furnish down there, to the Portsmouth Naval Hospital. That is the procedure that we are going to follow with patients who come under Courts Martial jurisdiction in the Navy Hospital -

their charges will be referred to the Army for processing. The final decision will have to be in a Joint-Army & Air Force Publication, or an amendment to the Public Law.

One or two suggestions were made that they go to this Session of Congress now and ask them to amend the Public Law; but, since the ink was hardly dry on the previous law, we felt it was better not to get started on that. We will try to get something out on it - possibly an SGO Circular coordinated with everybody, including the JAG upstairs, to give us an interim measure.

COLONEL HARTFORD:

Any questions?

GENERAL WILLIS:

The speaker just mentioned the TIE Program - a survey of this has already been requested of our Center - The Brooke Army Medical Center, by the Fourth Army, is now in the status of preparation. We have to prepare duplicate reports of these things - will a report to The Surgeon General be required if we submit it through the Fourth Army?

COLONEL JOHNSTON:

This has come up frequently. In this specific instance, I think it should come through the Surgeon General's Office.

GENERAL WILLIS:

It has gone through the Fourth Army.

COLONEL JOHNSTON:

We are making the consolidated report for all Class II installations.

GENERAL WILLIS:

The second thing - is in reference to the disciplinary actions in the case of Air Force patients. You should include in your decision or directive, such as is applicable to the school as well as at Brooke Army Medical Center. We have some six hundred cases to which it is applicable, some 150 or 200 in the school and the balance in the hospital.

COLONEL JOHNSTON:

I am sorry, I failed to mention that. We will take that into consideration. I have your letter here now, sir.

COLONEL HARTFORD:

Colonel Schwichtenberger would like to have a few minutes.

COLONEL SCHWICHTENBERGER:

During a part of 1943 and early 1944 it became evident that this Office was losing touch with the hospitals and the Field generally. Our problems had reached serious proportions before this office found out about them and was able to initiate action of a corrective nature. We had, at the same time, individuals, from the various sections in the office going out and making their routine staff visits, each one of which was making a report. The circulation of that report generally being rather limited within the office, and each one in itself further being limited by the fact that the individual concerned looked at the hospital from the standpoint of the surgical consultant or the medical consultant and so on, and no one, therefore, was able to come up with an evaluation of the problems arising in the hospital and the suggested solutions for them, in a well rounded manner. As a result, we evolved a system of visiting hospitals whereby members of each of the major staff sections of The Surgeon General's Office furnished, generally, their top or second from the top man. So we had in the group that left this office and proceeded around to the various hospitals representatives from all of the major sections of the Office, and we stopped in hospitals, usually spending a day in each one.

The procedure was that, generally, we would arrive in the evening having spent the day in one hospital and proceeding by air in the late afternoon to the next one. Usually there would be gathered at the hospital Chiefs of Services and Sections and the key personnel, and there would usually be an informal meeting of the two groups and plans were layed for the following day's activities.

The way in which the group worked in the hospital was very simple and evolved as time went on along these lines: That, The Surgeon Consultant went along with the Chief of Surgical Service in the Hospital--the Medical Consultant from this office went with the Medical Chief of Services. We had some from resources & Analysis Section. The action which he frequently did--he would go to the Registrar and various people who prepared reports and he used them, as a basis for his informative material in this office.

We had representative from Construction and he would go with your hospital engineer and so on down the line. Thereby each individual really having at the moment then a representative of this office in the

hospital.

I am sure that what I am saying is a repetition of what some of the Hospital Commanders already know, since they are familiar with it from those days.

After spending the morning in the hospital and after lunch, usually there would be a conference of the entire group. At this point everybody would have a chance to speak his piece and come up with recommendations that were going to be made in the written report which followed. We felt that that was the most helpful thing that was done in my division and in the entire Surgeon General's Office during that period, for it not only kept us abreast of the problems that were arising, but I think it gave the individuals in the various hospitals that we visited a chance to see what our problems were in the over-all way.

As you see, there was no time for any social activities at all because of the face that we didn't spend more than about a day in each hospital. I think that would probably be the way it will have to be done again. I realize and I know that all of us realize that it isn't possible to learn all about a given installation in that short a period of time. We felt, however, that it was possible to learn the most important features during that interval, and so we felt that it was about the best compromise that could be made--the initiation of a similar program in the near future is partly contingent upon our securing a large aircraft to take the group around, but I feel sure that that can be done.

So, with the possibility of that problem not becoming insuperable, you can expect to see us as a group once or twice a year as conditions permit.

COLONEL HARTFORD:

I have heard nothing but good reports about Colonel Schwichtenberger and the old "Flying Circuses". But I am reminded of a little joke that one of our rather prominent generals, now in the War Department, pulled, to-wit; "If all the War Department Inspectors were layed end-to-end, he thought it would be a good idea."

In our invitations that went out to you on the 19th of June--in the confidential letter which General Armstrong sent, we asked for your ideas on certain subjects such as employment of civilian doctors, training program and so forth. I think, perhaps, some of you have prepared something in writing on that. We have received some of them already. If others have those along, I would like to get those by noon today. I have General Willis' letter.

Gentlemen, we have arranged a little recess now. We thought it perhaps should come a little early this morning (now 9:40), and we would like to start again promptly at 10:15.

COLONEL HARTFORD:

Gentlemen, the question came up yesterday afternoon in the discussion of several hospital commanders relative to transfer of Air Corps patients. There is an Air Corps letter, Personnel News Letter No. 5, Department of the Air Forces, dated 1 July 1948, which probably is just arriving in the field. In regard to administrative procedure, it says the following: Normally when it is determined that a patient will be transferred to a General Hospital for 90 days or less hospitalization and will not be required to meet a CDD disposition or retirement board, the transfer should be accomplished as a temporary change of station. A provision should be included in the transfer order that on completion of hospitalization the individual concerned will return to his proper station unless other disposition becomes necessary. In this connection, a decision by the Office Comptroller, Headquarters, U. S. Air Forces, indicates that a temporary transfer between hospitals is probably chargeable on LTM for temporary duty travel. When it's believed a patient will be hospitalized for a period in excess of 90, or will be required to meet one of the boards, etc., the transfer should be accomplished as a permanent change of station. Then there is a final admonishing paragraph which it may be necessary or desirable to call to the attention of the commanders in the field as follows: In view of the fact that some stations have misinterpreted certain directives, this office has recommended that the Office of The Surgeon General and Department of the Air Force publish a joint directive to supersede the aforementioned circulars. That joint directive is being prepared. It may be desirable to call their attention to it because they actually may not have it yet.

The Committee report that you heard yesterday - the mimeographed copies which were distributed to you - we have a few extra copies and if anyone has any need for them we would be glad to furnish them to you.

Next we would like to take up Hospital Construction and Rehabilitation which will be presented by Colonel Tynes.

COLONEL TYNES:-Hospital Construction and Rehabilitation.

Last fall when it became increasingly evident that favorable legislation was going to be passed by Congress in support of Universal Military Training, we were directed by the General Staff to make a survey of the camps and posts which were tentatively selected for use by the Universal Military Training personnel. Accordingly, representatives of the Hospital Construction Branch and a representative of the Chief of Engineers with representatives of the respective Army Commanders made a rather thorough physical survey of the 23 stations which were proposed at that time for use in the universal military training program.

Since the individual surveys were made by the same group using the same standards as a basis for evaluation, we were able to fairly compare

the physical condition of the facilities comprising these 23 hospitals. Furthermore, we were able to compile a list of the work items necessary to renovate and reactivate these particular hospitals on a sufficiently high standard. The summary of our report with recommendations was submitted to Logistics and at that time was approved. Later, when Congress shifted from Universal Military Training to Selective Service, our recommendations remained unchanged and, of course, the requirements for renovation of those hospitals remained unchanged. When the Bureau of the Budget requested the Medical Department to support its proposed renovation program of these hospitals to provide for the selectees, we found that we were in a very good position to defend the proposed program to renovate and rehabilitate our hospitals. For rehabilitation of posts and camps (that is, to renovate barracks, build roads, etc.), the Office of the Chief of Engineers asked for $50 per man for the increase in strength of the expanded Army. The Medical Department asked and obtained approval for $1,025 per bed for each additional bed which would be required for the expanded Army. When the Selective Service Act was passed, Congress appropriated only two-thirds of the funds requested, therefore, the Medical Department had to take its cut along with the rest of the Army. There was, however, $8,250,000 allocated for the Medical Department which was to be used for renovation of General and Station hospitals in the Zone of the Interior, exclusive of the Air Forces Station Hospitals. On 19 July we addressed a letter to Director of Ligistics asking that the Chief of Engineers be immediately directed to start the renovation of our hospitals as we had previously recommended in order to bring them up to a sufficiently high standard to meet the requirements of the Selective Service Law. I have a few copies of the letter here. I'll pass them around and we can get additional copies for you tomorrow. This letter listed the number of beds that The Surgeon General recommended be set up in both Station and General hospitals. The list, I might say, has changed somewhat and I'll give you a plan showing the actual bed capacities as now proposed. Also listed in order of priority are those steps which we had previously recommended as being necessary in order to renovate our hospitals and bring them up to the required standard. I'll discuss that list in detail in just a few minutes.

On 29 July, General Aurand sent a letter to the Chief of Engineers which I think will be of interest to all of you since it is relative to the renovation of your hospitals. This letter in effect instructed the Engineers to use our previous letter as a guide for planning purposes; it did not definitely direct them to accomplish all of the work items which we had recommended as necessary to renovate and rehabilitate these hospitals. It did, however, specifically state that $8,250,000 of the money appropriated for renovation of camps and stations was earmarked for use on hospital facilities, and further, that the hospital facilities would be renovated to a higher standard than those of the rest of the post. We were most anxious to get this across and we felt that directive form was necessary. Previously, a letter from The Adjutant General dated 12 May 1948 had been sent to all camps, stations and engineer offices, defining the standard of rehabilitation and improvement of inactive stations for Selective Service. Three standards were established: "Standard "A",

which is the minimum standard necessary for the accomplishment of the mission; Standard "B", which is a little higher; and Standard "C", defined as desirable or sufficient to establish and support good morale - in application equal to economical standards normally applied in good commercial or State programs for comparable medical facilities. Now, the directive from General Aurand states that, insofar as the available money lasts, we will effect Standard "C" in our hospitals. It will be the responsibility of you people in the field to make certain that a higher standard is given to our hospitals, when that money is spent. If you don't assume that responsibility, I don't know that we will get our fair share of this money. Of course, there is one joker - the money was not given to the Medical Department and we have no direct control over it as we formerly had in the control of C and R of H funds. The money has been allotted to the Chief of Engineers, who, in turn, will allocate it to the various Armies. We are on very good terms with the Chief of Engineers' Office, and we have been assured that everything in their power will be done to see that we get our share of the money.

Naturally, the hospitals that have been closed that are to be reactivated, such as Pickett and others, will require the expenditure of more money for renovation than those hospitals that are in operation. Also, the cantonment type hospitals that are in operation now will require more money and should have more money for renovation than our more or less permanent hospitals. These points are not mentioned anywhere in this directive but they should have your considered judgment in the programs you will submit.

Coming back again to the list of individual items which we recommended in this renovation program:

First of all, we must protect the buildings from the elements. That is, replace or repair roofs, gutters, downspouts, porches, steps, etc.

The second item is to correct any structural weaknesses. Buildings must be made safe.

The next item is to repair or replace existing plumbing fixtures electrical fixtures, heating units, ventilating equipment, air conditioning equipment, etc., as necessary. All window glass and insect screens on windows and doors should be repaired or replaced. We have a tentative agreement with the Chief of Engineers that certain of the hospitals in northern sections of the country probably need not have the screens replaced on the open porches of the cantonment type wards. I think it was a mistake in general ever to have built those porches in the northern part of the country; they have never been used and they cost extra money. Repair of porches will be left to your discretion; if you want to use them and have used them, they should be screened.

Fixed medical equipemtn should be replaced or repaired wherever required. We found that in a number of operating rooms the sterilizers had been removed; in other cases, water stills had been taken out and

other equipment of that type had been removed. We want to install a combined washing and flushing type bedpan sterilizer in the utility rooms of all the wards. In order to expedite the procurement of these items of fixed medical equipment, we have agreed that unless they are available locally or can be provided by a medical supply depot, the responsibility for their procurement will rest with the Engineers and will be made a part of the contract for renovation of the building. The money for this purpose will be made available from the M&HD fund. Items other than medical equipment, of course, must be repaired or replaced as required. The Quartermaster has indicated that his funds are small and therefore wanted to install what he terms "Class 4" items of equipment in the messes. The Quartermaster has just as much money as we have, in fact, he has more money - considerably more than we have - and I believe he can afford to purchase new equipment more ably than we can. Certainly "Class 4" equipment for the kitchens and the diet kitchens is not in accordance with the defined "C Standard".

I have discussed this matter with the Chief of Engineers and requested that they insure the provision of good quality equipment by the Quartermaster, the procurement of which is the Quartermaster's responsibility. I hope that you will follow up this matter, and if you do receive "Class 4" equipment for your kitchens, you will reject it and insist that better quality equipment be supplied.

We feel that many hospitals will require interior painting throughout, therefore we have placed that item next in our list of priorities. Again, however, you should use a little discretion and don't insist on new paint in all of your buildings if in some of them the paint is in satisfactory condition. We know our funds are insufficient and this may be one item on which we can save and thus accomplish other items.

The floors of the buildings in a number of hospitals are in very bad shape; they should be improved to "Standard C". You may find that sanding is sufficient in some areas, while other areas will require complete new surfacing or patching of the surfacing material. In all cases, the floors of hospital buildings should be in good condition throughout.

Certain buildings will require alterations, the extent of which will depend somewhat on your individual requirements. We found that practically all of the X-Ray clinic buildings had deteriorated very badly and would require a complete renovation throughout.

We are very anxious to accomplish the item of alteration of enlarging private rooms, in at least half of the W-2 type wards of the cantonment type General Hospital, to provide more space where we treat our sickest patients. All of you are well aware of the fact that these very small rooms (72 square feet) are entirely inadequate to furnish proper nursing care to patients who are really sick. Plans have been prepared and are available in the Office of the Chief of Engineers, showing how the W-2 ward can be altered to provide twice as much space in each one of these private rooms. The alteration consists of removing the partition between

every other private room. By this alteration we lost 4 beds in each ward we converted but the over-all loss of beds is small and is out-weighed by the advantage to the patient and to our doctors and nurses. I have prints of the original sketches here showing this proposed alteration which you may look at and, if you need them, you can get copies through the Office of the Chief of Engineers. (Passes around prints.)

We hope to have sufficient money to alter the nurses' quarters. A recent survey of Army and Navy hospitals of this country showed that the difference in the standards of living accommodations of our nurses and those of the Navy nurses was appalling. The General Staff is aware of this fact and is very sympathetic, realizing that better living conditions for our nurses are required if we are going to have a successful recruitment program for the nurses. Unfortunately, alteration of the cantonment type nurses' quarters is an expensive job and you may not have sufficient money to do it, however, the Staff is sympathetic and may possibly appropriate additional funds later to complete alterations to nurses' quarters if you want it as a part of this program. These prints show suggested alterations to the nurses' quarters of single story cantonment type quarters and provides at least a private room for each nurse and a connecting bath for each two nurses. A glance will show that this alteration will be expensive but you may have sufficient money to complete the program. These present quarters for nurses are terrible and we definitely want to improve them in every one of these hospitals. The Staff is willing to raise the priority of this item if we request it.

We hope that you will have sufficient money to install in your hospitals a radio system and utility outlets for each bedside table, at the hospitals where these do not presently exist. I think most of the hospitals have some type of nurses' call but those that do not have it should, if possible, save enough money to provide a complete installation throughout the entire hospital.

The remainder of these items in this letter are too low in priority for us to believe that funds will be sufficient to accomplish them at this time, but if you do have money available, we feel that connecting corridors should be ceiled the same as other buildings that are not now ceiled. Also, we feel that something should be done for the enlisted personnel in the hospitals. That is, improvement to their barracks, such as floor repair and improvement and installation of surfacing material on walls and ceiling. Along that line, may I stop just a minute and state that we are not actually fighting a war; our emergency is nothing like as great as it was in the latter part of the last war when we were forced to take over our barracks to provide patients' beds. We do not believe this should be done at this time and we do not recommend it. Mr. Cogan is anxious to get every bed possible; but additional patient beds should not be provided at the expense of our enlisted men's barracks unless suitable cantonment type barracks are available in close proximity to the hospital.

I have here the latest proposed bed capacities of the General Hospitals. I'm not going to ask you to comment on these now because General Hays is going to talk about this in a few minutes. These

capacities are still not official but I think we will probably go up to Staff following this meeting and ask that they be made official if you concur in them.

Now, make every effort to assure that the money is spent on our hospitals and not spent on fixing up somebody's swimming pool. Let me repeat, we don't have sufficient money to do everything that is necessary, but those who request funds first will, in all probability, get the lion's share of funds available, so let me urge you to talk over the matter with your Post Engineer, when you return to your station, and apprise him of this recent directive to which I referred. Have him work out a program for your particular hospital, immediately, and request the funds to effect your program. If we can help you, we will be glad to do so. At the present time,Major Allan, of this office, and Mr. Hasle, Chief of the Food Service Program, Office of the Quartermaster General, are making surveys of the messes and the diet kitchens in an effort to effect much needed improvement. If these representatives have not been to your hospital and you have urgently needed changes, I suggest that you write in and ask that they visit you as soon as possible before you purchase improper or unsuitable equipment. I repeat, if anyone from our shop can help you in designing alterations or changes to your facilities, as may be necessary, we'll be glad to assist you as far as we are physically able.

COLONEL HARTFORD: Are there any questions?

GENERAL OFFUTT: As I understand it, you say you don't want us to go into barracks?

COLONEL TYNES: Your hospital is one of the exceptions. At Custer we feel that, since you have the entire post, you can take over cantonment type barracks next to your hospital. That would possibly be true of Gordon and I know it will be true of Atterbury.

COLONEL HARTFORD: We have made a little change in the agenda and General Hays is going to speak next on EQUIPMENT AND SUPPLY PROBLEMS:

GENERAL HAYS: I would like to go right ahead from where Colonel Tynes stopped and we have all had a chance to look at those expansion figures so are there any comments as to the practicability or non-practicability of the proposed expansions?

GENERAL STREIT: Can you tell us whom we can go to, to find out how much money will be available to our hospitals?

COLONEL TYNES: We do not control the money nor do we have any part in determining how it will actually be spent. The R & U Branch of the

Chief of Engineers will allocate funds to respective Armies. You submit your project in the same manner as you would any repair or maintenance project, however, ask that it be financed from money made available for hospital facility renovation as a result of the Selective Service Act.

GENERAL WILLIS: Will any of that money be available for hospitals not included in this expansion program?

COLONEL TYNES: Yes.

GENERAL WILLIS: Why don't we clean up what we already have?

COLONEL TYNES: If we could clean up all the projects we have on hand it would be good, however, the final approval does not rest with us. It is a job that must be done immediately and the Army Engineers are going to carry it out. It is based on obtaining adequate General Hospital beds for the entire Army wherever they can be provided.

GENERAL HAYS: Are there other comments on the practicability of expanding the hospitals to the sizes proposed? Do any of the commanders feel that their hospitals should be larger than is indicated here?

COLONEL WILLIAMS: At Fort Bragg we have 3 main hospitals; if we expand to 3,000 beds we will have to have new construction.

COLONEL TYNES: There will be no new construction authorized by this program; that is the law.

GENERAL HAYS: Does that require a change?

COLONEL WILLIAMS: It will require a change in our capacity. I think, by utilizing space, we can convert to take care of 2,000 patients.

COLONEL TYNES: We intend to go down to Fort Bragg next week and survey your hospital; let us wait until then.

GENERAL HAYS:- Equipment and Supply Problems.

As far as the supply picture is concerned, I would first like to give you a little background on the fiscal side. As you all know, our 1949 budget was computed by this time last year or a little earlier, and it was then cut a little bit by the Budget and Advisory Committee by the Bureau of the Budget. In the last few days of Congress we were told to put in a sup-

plemental appropriation but we were given a very small limiting figure. According to our computations, we actually received for supplies and equipment, little more than will take care of the maintenance of the increased troop strength, plus $425,000 for initial equipment. The initial equipment is not only for hospitals but for troops, medical battalions, etc. We figure that this $425,000 represents less than 15 per cent of the money value of the supplies required to take care of complete initial equipment. I bring that out as background so you will understand that this year we are going to be very very tight on money. We will, in all probability, have to to to the next Congress in January or February, and ask for a deficiency appropriation; your guess on what our success on that request is as good as mine. The modernization program which we undertook at the beginning of this calendar year will definitely have to go into a state of suspension until we are able to meet our expansion requirements. We are not throwing it out of the window, but it is going to have to be suspended until we can equip all of the new hospitals that are involved in this expansion program. In equipping these new hospitals, as far as we know they are going to be just as permanent as any of the existing hospitals. Consequently, they should receive the best equipment that we can afford to put in them. In other words, we shouldn't install in these new hospitals, poor equipment which we have taken out of our existing hospitals. So I hope that you will bear with us on the delay in the modernization program.

We are trying to determine now just what assets we have in the way of equipment. As you all know, there were a good many stations placed in stand-by status during the last few years. A certain amount of equipment was kept at those stations of which we have no record. Some of the General Hospitals have a considerable amount of stand-by equipment on hand. We are attempting now to find out how much equipment there is nationwide so that we can gear out procurement program to our actual needs. I would like to emphasize that we want to beat the bushes and get into use every bit of this stand-by equipment. We have asked the cooperation of the Army areas and the Air Force Commands in utilizing all the stand-by equipment they have on hand in stations which are not being expanded, before they call on the depots for equipment for expansion. There is also a great deal of equipment that is out in the field that is unserviceable. We are conducting a vigorous program of repair wherever it is economically feasible to repair that equipment rather than purchase new equipment. We conduct a maintenance and repair school at St. Louis. The last two months of that course is on-the-job-training. We have 7 officers and 35 enlisted men that have entered that phase of training and we have made them available to each of the distribution depots to send out to various stations on assignment in this maintenance and repair work. If you want to get these teams in your hospitals, call on your depots and if possible they will make these men available to you to assist in inspecting your equipment, actually repairing what they can, or assisting you in getting it repaired.

We are also making use of our modernization committee, headed by Colonel MORGAN, to assist you in your expansion program. That committee is going to visit installations all over the United States which are to be opened or undergo expansion. They have already been to Fort Devens which is to be opened very shortly. If you want assistance from that group drop

me a note or let me know while you are here, and we will see if we can work your place into their schedule. I think they will be of considerable help to you. The expansion is going to force us into the use of certain sub-standard equipment. For example, we are going to have to utilize to some extent the field-type folding beds and cotton mattresses, rather than innerspring mattresses. We are now investigating the possibility of converting some of our cotton mattresses into innerspring; our studies to date indicate that this is not economically feasible, however, we may find that it will be. If it is economically feasible, then I can assure you that all of your expansion beds can be equipped with innerspring mattresses, perhaps not initially, but at least before the end of this fiscal year. The bedside table situation is particularly bad. We entered into a contract a year ago for 16,000 bedside tables. The manufacturer has been unable to procure steel for those commodities except in small quantities to date, and deliveries are very very slow, so it may be that you are going to have to use the field-type of bedside table; at least until deliveries do come in, which may be a good, many months. I mentioned photoroentgenographic units this morning. During the war we procured approximately 300 of those units and they were put in use all over the country. Theoretically they are still on hand because they were never on the list to be declared surplus. The information that we have been able to gather to date as to where they are is quite sketchy. We are pursuing this and trying to get all those photoroentgenographic units into use. You may very well find that you have some of that equipment on hand stashed away down in your warehouse someplace. I wish you would give particular attention to that in trying to help uncover it and then, if you can, use it in the induction program. In other words, if your place is going to be used to take chest X-rays, then use it, otherwise, turn over to the Army Surgeon to utilize at the induction station. Are there any questions that anyone has? (No questions)

COLONEL HARTFORD:

Several references have been made to physical examinations during discussions here and Colonel BORNSTEIN will present the subject and what we have been able to do up to date on this subject.

COLONEL BORNSTEIN:- Physical Examinations.

Gentlemen, I am sorry that the Chief of the Physical Standards Division is not with us here today; Colonel Nylen is presently convalescing at Walter Reed General Hospital and we hope to have him back with us in the very near future.

I have been asked to say a few words on the subject of physical examinations. I will attempt to present some of the recent "highlights" relative to this subject.

At the request of The Surgeon General, a committee is presently making a complete survey of the problem relative to the types of physical examina-

tions accomplished in the Army. This survey, of course, requires a thorough review of all directives pertaining to this subject including a review of all pertinent Federal statutes. We are studying the frequency of all physical examinations and, after a complete sutyd, we hope to arrive at a definite recommendation as to the essentiality or non-essentiality of specific individual physical examinations. We hope, as a result of this study, to arrive at some beneficial recommendations so that all personnel concerned will be spared the burden of either accomplishing or undergoing what may be considered to be an "unnecessary" physical examination. Thus far, we have made a fairly complete review of the various directives relative to the subject of physical examinations. It really is surprising to learn the great degree to which references are made to the subject of physical examinations. It sure would be very helpful if we could have a single Army regulation pertaining to the subject of physical examinations, whether it pertained to application for Extended Active Duty, Commission in the Officers' Reserve Corps, etc. Such an Army Regulation could contain all necessary data such as required channels, pertinent physical standards, reviewing authority, etc.

I might mention that we have already taken some active steps with respect to the subject of active duty training. We have received quite a bit of correspondence on this subject, particularly where it concerns individuals ordered to active duty training for periods not in excess of 30 days. I believe that, by this time, you have all probably received a copy of War Department Clear Message 42583 dated 23 July 1948 which, in effect, states that an individual ordered to active duty training for periods of 8 to 30 days may, in lieu of the presently required physical examination (unless indicated) accomplish a certificate provided such individual certifies that he has been found physically qualified for active duty as a result of a physical examination accomplished within one (1) year preceding the date of active duty training.

I might add that War Department Memorandum 600-150-1 dated 11 September 1947 (as amended), which pertains to the entire subject of active duty training for members of the Officers' Reserve Corps and Enlisted Reserve Corps has been re-written and it is expected that the proposed directive will be approved and distributed to the field within the very near future. It is expected that this new directive, when placed in operation, will serve to eliminate the accomplishment of any "unnecessary" physical examinations and also help to expedite the administrative procedure relative to the entire problem of short tours of active duty training. In this proposed directive we have recommended the following: (a) individuals ordered to active duty training for a period of 7 days or less will not be required to undergo a physical examination unless indicated; such persons will only be required to accomplish a certificate (relative to their physical status) upon reporting and upon relief from active duty training; (b) Likewise, individuals ordered to active duty training for a period of more than 7 days but not in excess of 30 days will not be required to undergo a physical examination unless indicated; such persons will also be required, however, to accomplish a certificate (relative to their physical status) upon reporting and upon relief from active duty training; (c) Finally, individuals ordered to active duty training for a period in excess of 30 days may either

undergo a final type physical examination or accomplish a certificate prior to reporting for active duty. An individual who undergoes a final type physical examination prior to reporting for duty will only be required to accomplish a certificate upon reporting for duty and also upon relief from active duty training (unless the accomplishment of a physical examination is specifically indicated).

An individual who accomplishes a certificate prior to reporting for duty will be required to pass a final type physical examination upon reporting for duty and accomplish a certificate upon relief from active duty training (unless the accomplishment of a physical examination is specifically indicated).

The question of granting of waivers has also been a big problem. To help this situation, we have recommended, within this proposed directive, that authority to approve waivers of physical defects in the case of those individuals whose tour of active duty training is not to exceed 30 days, may be delegated to commanders of such installations as the Area Commanders may direct. In the case of those individuals whose tour of active duty training is to exceed 30 days, Commanding Generals of Area Commands are authorized to approve waivers of physical defects (below general service requirements).

Thus, in order for an individual to be considered physically qualified for active duty training, he must meet general service or general service with waiver requirements. The physical classification entitled, "General Service with Waiver" refers to an individual who has a physical defect (s), which in the opinion of the reviewing authority (a) is static in nature (b) is not subject to complications or aggravation by reason of military duty (c) will not interfere with the satisfactory performance of full military duty and (d) will, in all probability, not necessitate hospitalization or time loss from duty.

In considering this physical classification of "general service with waiver", one should take into consideration an individual's age, grade, and branch of service.

The term "General Service with Waiver" should not be used synonymously with the term "Limited Service."

Colonel Hudgett made reference this morning to the fact that all reports of physical examination utilized by the Service Have been standardized. A single set of medical examination forms has been designed to replace the large number of such forms presently in use by all Federal agencies. (Army, Navy, Civil Service, etc.). As you probably recall, a field trial was carried out last year within all Army Areas for the purpose of testing the practicality of these forms. In general, these forms were accepted enthusiastically by the field. The report of Medical Examination will be known as Standard From No. 88 and the Report of Medical History will be known as Standard Form No. 89. The distribution of these standard forms will probably be made during the early part of November of this year. As far as is known, the use of these forms will probably be mandatory after 31 December 1948. These forms have been designed so that they may be used separately or in combination in accordance with administrative requirements.

Before closing I would like to touch very briefly on a point with which I am sure you are very familiar - that is, the subject of incomplete data on reports of physical examination. Gentlemen, I do not mean to be facetious, but we are required, not too infrequently, to return reports of physical examination to the field for the inclusion of supplemental data. We do not enjoy doing this, and I am sure that you gentlemen do not enjoy receiving such requests. However, it is necessary, of course, to have sufficient medical data upon which to evaluate each case. If sufficient supplemental information was supplied when indicated in a specific case it would surely obviate a great deal of administrative work and expedite the processing of each case by this office. For example, we may receive a report of physical examination with an entry such as "30 degrees limitation of flexion of right elbow"; unless such report is accompanied by more detailed supplemental information in the form of an orthopedic consultation we are required, in most cases to return such report of physical examination to the field requesting the necessary data.

Medical officers performing physical examinations should be thoroughly indoctrinated with pertinent regulations and directives.

Medical officers who conduct physical examinations in an indifferent manner are not b ing "fair" to themselves, to the individual being examined, to the medical profession, or to the Government.

I see that my time is up - if there are any questions I will try to answer them.

Thank you, Gentlemen.

GENERAL OFFUTT:

Will you give me again the number of that message you made reference to?

COLONEL BORNSTEIN:

War Department Clear Message 42583, 23 July 1948.

GENERAL WILLIS:

You spoke of certificates in lieu of examinations. Is a certificate by a civilian physician acceptable in lieu of physical examination? Lots of reserve officers come in with certificates from a civilian physician stating that they are alright.

COLONEL BORNSTEIN:

The certificate, General Willis, is stated in such a manner that I believe it would have to be accomplished by the individual himself. May I read a sample of the proposed certificate which is accomplished when the individual reports for active duty training. "I now consider myself sound

and well and physically qualified for full military duty. I was considered physically qualified for military service at the time of accomplishment of my last physical examination on or about (date) at (place). To the best of my knowledge and belief, I have no physical defects or conditions except as noted below, which would preclude the performance of full military duty."

GENERAL WILLIS:

Does it make any difference who accomplishes that last physical examination - whether it is a civilian doctor or a medical officer? A lot of people state that "I was examined by so and so and I'm alright." There is no record at all of such examination.

COLONEL BORNSTEIN:

That last physical examination (referred to in the certificate) does not necessarily have to be accomplished in an Army medical facility. A physical examination accomplished by a civilian doctor would be considered acceptable inasmuch as current directives permit the accomplishment of physical examination by civilian doctors in conjunction with an individual's application for commission in the Reserve Corps.

GENERAL STREIT:

How do you figure that this is going to reduce the number of examinations by requiring this man to have a certificate that he was examined within the last year; that won't reduce the great lot of people that are being called back to active duty for shorter or longer periods who have not had the physical at all?

COLONEL BORNSTEIN:

You mean the ones who have not had the physical examination within the past year?

GENERAL STREIT:

Yes.

COLONEL_____:

Recently, Colonel Johnston went to New York City and found out some facts after the issue of that particular telegram; they still had to examine 75 per cent and were trying to work it out so that they would have to give them only one physical during any one term of appointment in the Reserve Corps.

COLONEL STREIT:

I think that would be something more practicable. At Brooke they have got to do almost a hundred a day at the present time, exclusive of Civil Service officers coming on; promotion examinations and all that sort of thing and it seems to me that we ought to work on accepting a certificate from these people to come on active duty that as far as they know, they are well and let them do 20 or 30 or 40 days duty. I don't see the point of having a physical examination when you come on duty and 7 days later giving you another.

COLONEL BORNSTEIN:

Individuals coming on active duty for a period of 1 to 7 days are not required to take a physical examination unless indicated. Under the proposed directive relative to active duty training, the certificate accomplished upon relief from active duty will read as follows: "I certify that during the period of active duty training from (date) to (date), there has been no change in my physical condition and that I am not suffering any disability or defect which was not present at the beginning of such tour of duty."

COLONEL GREEN:

Why not have the individual accomplish one certificate to take the place of the two certificates you mentioned - that is, upon reporting and upon relief from active duty training. For example, "I think I'm well and the 7 days I have been on duty I don't think I got hurt."

COLONEL BORNSTEIN:

That is something we will take into consideration.

GENERAL WILLIS:

I don't think what you have done to reduce the number of examinations will help a great deal.

COLONEL BORNSTEIN:

General, we have only touched the surface so far; we are studying this matter at the present time. This War Department Clear Message 42583 to which I have referred is purely an emergency measure to help in expediting processing of individuals coming on active duty training for periods of 8 to 30 days.

GENERAL WILLIS:

Did you take care of that question of the audiometer test for hearing and the refraction that is required for every ROTC student that is examined

at camp? It was taken up at the Army Surgeon General's conference here and got a temporary reprieve so that we didn't have to do these tests on all students.

COLONEL BORNSTEIN:

This is a recommended change that has already been sent to the staff. With reference to that point, the recommended change reads as follows: "The physical examination made at the camp will be made primarily with a view of determining the student's physical qualification for a commission in the Officers' Reserve Corps. The scope of the physical examination, however, will be as prescribed in AR 40-105 for original appointment in the Regular Army. Individuals who are manifestly physically disqualified for appointment in the Regular Army because of visual, auditory, or other physical defects will not be required to undergo refraction or audiometric test, unless indicated."

GENERAL WILLIS:

That only takes care of a very small portion of students. It is those that don't have any obvious defects in hearing that have to be tested by the audiometer; that is the great delay in processing those ROTC students.

COLONEL BORNSTEIN:

I will make a note of this, General Willis, and we will look into this problem.

GENERAL WILLIS:

But these students have to be examined again when they come up and they won't come up for at least 2 years and maybe 3. Why should we have to make a test of every ROTC student and why should we have to refract every student that has a minor error in vision just so he can stay in camp 6 weeks and, if he has anything, then you waive it and if he comes in the Regular Army, he has to go through that same thing 2 years later?

COLONEL BORNSTEIN:

That is a good point; we will look into it.

GENERAL WILLIS:

Every one has been to a doctor for a physical examination when he enters camp and gives a certificate when he leaves camp. If you try to refract every one of those ROTC students, you run into something. If you take

an Audio test, you can't do it in less than ten minutes; that is 6 an hour and with 700 people that is quite a job. This can be omitted in cases of obvious defects but that is not important; those cases amount to only 2%.

COLONEL BORNSTEIN:

We will make an immediate study of that problem.

GENERAL OFFUTT:

Did I understand you to say that you don't waive the physical examination on less than 30 days?

COLONEL BORNSTEIN:

The accomplishment of physical examination is waived in the case of those individuals coming on active duty training for periods not to exceed 30 days. A physical examination is not required unless indicated.

GENERAL OFFUTT:

Thirty days or less you don't give them a physical examination?

COLONEL BORNSTEIN:

That is right, sir; the certificate will suffice unless a physical examination is indicated. I'll make some true copies of War Department Clear Message 42583 of 23 July 1948, and see that they are distributed to those of you who do not have a copy. (Several raised hands indicating they would like copies.) We will do that this afternoon.

COLONEL HARTFORD:

Colonel DUKE will now give his presentation on PROFESSIONAL TRAINING.

COLONEL DUKE:

I'm not going to bore you with the Professional Training program because you are operating it; I merely want to bring you up to date and then discuss very briefly one or two phases which may be affected by the current shortage of personnel. You were told that the decision has been made to continue the Training Program as it is. The program in our 5 teaching hospitals is almost completed. I mean it is completely approved and firmly established as far as the AMA and Specialty Boards are concerned. (Referring to Chart). There are 77 programs on this chart; 70 of which are approved. In other words; there are only 7 of the 77 on which we do not have final

approval, so I say that the program is almost complete in these 5 hospitals.

We have been criticized by some of our officers in Army Areas and Field Forces as to the number of people we are training. We are not trying to make every officer in the Medical Department an expert or specialist. This whole training program is formulated on very definite requirements. You will remember sometime ago I showed you figures where our Personnel and Resources Analysis Division indicated we need about 800 men of the expert category. We need at least 700 if we are going to provide the type of medical service that we think should be provided for a peacetime Army. We have about one-seventh of the number we need. If we continue the program as it is now, it will take us from 5 to 6 years to meet our minimum requirements of this caliber of personnel; so the time may come within 5 or 6 years when we will have to curtail this program and cut down on the number in training. Certainly we don't want or need a Medical Service with 99 or even 50% specialists. We are merely trying to meet our minimum requirements over a period of 5 to 6 years. Due to current personnel shortages, we will have to curtail our civilian institutional training program. This is especially true of the long term courses. We can't afford to send 12 to 14 officers every year out to the Public Health course; we are going to have to cut it down to half, or one-fourth that number. We are going to have to insure that we are not sending out to civilian institutions officers for training when we can provide that training within our own residency program.

We must weed out of our Residency Program, the men who are not up to par. We know that there are certain residents in our training program right now who are coasting and who probably never will be the high-type professional man that we want as Chief of Services and Sections of our hospitals. We are depending on you and your educational committee to tell us who those men are. Your first evaluation reports didn't help us very much because they looked alike. We gave you a different type of report and required that you line them up in each specialty from one to five to let us know who was number one and number five. We want your Educational Committee to call a spade a spade; be very frank with your evaluation of these men and tell us the man who you think should not be in resident training. In general, when an individual has had 3 years of training, he will leave the General Hospital and go into station hospitals for duty in his specialty. We have about forty-six officers completing their 3 years of specialty training this coming year. Most of these will be available for station hospital assignments. It will be necessary to leave a few of them in our teaching system. Our teaching hospitals are not yet one hundred per cent perfect. They still need strengthening in some specialties.

One word about this new training program that we began at Madigan which we call training for clinical physicans. We found only 15 men who are interested in this type of training. We have assigned these 15 officers to Madigan for 3 years of general training. I don't know the future of this training program; I believe it will grow. I know it is in line with what American Medicine is doing. Many civilian hospitals and universities are now establishing 1, 2 and 3 years training programs for men who wish to stay in General Practice, so I know it is at least in line with what they are doing. Some universities are definitely against it; they believe the day of

the General Practitioner is gone and that group practice is the answer. At the same time, most everyone will admit that somewhere between 60 to 75 per cent of all people who seek a doctors services can be cared for adequately by a good general man. I like to think of it this way, it is generally agreed among Medical Educators that one year's rotating internship is not sufficient to train a man adequately. So I like to think that we are putting these 15 men out there and give them 3 years of rotating training in order to qualify them as good doctors. I think the time will come in 5 or 6 years, when we will cut down on this training program for specialists. At that time we could establish more spaces for the clinical physicians training. I think the time will come when we will be able to give every young doctor who comes into the Army 3 years of general training. This would insure that every Army doctor is an adequately trained general physician. Many may go on to specialization from here. That is a thought for the future. We hope next year to get an added interest in this 3 years training program and open Percy Jones for that type of training.

Now a word about R.O.T.C. We are expanding our Medical R.O.T.C. from 43 units - to 53 units this fall. We are also establishing 16 dental ROTC units; 6 veterinary, and 4 pharmacy. We just returned from the Medical Field Service School at Brooke Army Medical Center where the ROTC summer camp is in progress. We have 634 students at the present time there in the second week of training; 88 per cent are former service men. Many of them were enlisted men from private to Master Sergeant; 100 were former officers. Because so many were veterans, we eliminated some of the Military Training and gave them more hours in the hospital. After talking to that group I don't think we will have any difficulty in getting all the interns that we need next year.

One word about intern training. At the present time, you know, we have 108 interns in these five hospitals as far as I can learn from talking from some of the internes, they are all a well satisfied group. They like their internship; they feel they are getting good training. Next year we are going to open up 3 additional hospitals to intern training. This next year, we will place interns in Madigan, Percy Jones, and in the new Tripler Hospital. At the present time, Dr. Arestad from the American Medical Association is in Hawaii inspecting the Tripler Hospital for internship and resident training. We possibly will be able to put residents in Tripler within a year from now. We must expand this program slowly. I'm thoroughly convinced that we made a very wise move in limiting our Residency Training Program to 5 hospitals. It is a big procurement incentive right now. I know that the personnel division is very anxious to expand further than the 5 hospitals but I feel it would be a mistake to open Valley Forge at this time. There are certain definite requirements by AMA which must be fulfilled prior to establishing intern training. Fifteen per cent of your deaths must be autopsie; you have to have a minimum of 35 autopsies, your Staff must be acceptable to AMA. Obstetrics and Gynecology training must be adequate. At Valley Forge, that isn't true at the present time. Dr. Reed, one of the inspectors from the AMA inspected Valley Forge on 16 December 1947 and he wouldn't approve it for

internship training.

I'm going to conclude with this one little thought. In the formation of our future training programs in the Army, I feel we must never lean, as we have done in the past, too much to the professional side or too much to the administrative side. We must always realize that we have two very definite missions to perform. One, a peacetime mission of professional care of patients for a peacetime Army and their dependents, and two, the staff administrative, and command training necessary for mobilization. We must be able to furnish the medical leadership in that particular field. One mission is as important as the other. We should realize this and formulate our training programs to meet both of these missions; we can't get away from it, they are ours and they will always be our.

The Medical Reserve Training program is not adequate at the present time. The training of reserves is still a responsibility of field forces, it is not a primary responsibility of the Chief of Technical Services. I think it will eventually come under the Technical Service; I'm not sure of that but I think it will. There is one thing which is going on in one of our General Hospitals which I would like for you to know about and maybe assist in this Reserve training. Colonel Gates would you mind saying a few words about the set up at Letterman; about the local affiliation with the Army Area people to provide a little on the job type of duty for the reserves?

COLONEL GATES:

The result of an inquiry by local medical officers in our program - inquiry was made whether credit could be attained as a result of taking on a voluntary basis some of the local teaching program that was going on. By mutual agreement between the Army Surgeon and Headquarters, Reserve Section, our training officers maintain a register; any reserve officer, medical department, dental or MFC may sign a book and attend our training facilities and we report that to the Service Headquarters and they take care of giving that officer credit. Also members of our attending staff if they come on the hospital at a time other than which they are paid, if they come voluntarily for conferences and participate in it, then they may sign a register book and also obtain credit on their reserve training.

COLONEL DUKE:

There is coming out very shortly from the General Staff, provisions for reserve promotions. There will be provisions whereby an officer can take part in any reserve training program for promotion. So, if you can make a little affiliation with the local Field Forces people, Army area or Reserve people, and without interferrence at all, and I don't think it is interferrence with the training program at Letterman; these individuals could come in for 2 or 3 hours a day and that could be turned over to the local Reserve people and that man can get credit for being at the hospital for 2 or 3 hours a day. Are there any questions that you may have on anything that I said?

GENERAL STREIT:

The question of terminating the residency of those residents who are not doing satisfactory work. General Armstrong mentioned yesterday that there had been some difference of opinion or difference of policy in different sections of The Surgeon General's Office in reference to this matter. At Brookes we have recommended the termination of residency and the number of cases I had. We decided to continue these men for the remainder of the year, is that correct?

COLONEL DUKE:

When we first set things up, we said, here we put a man in residency training and we will evaluate information on his progress and at the end of a year we will determine whether he gets a second year. We left him there for the full year because of the necessity of getting a house and moving a family and so on; we left him there for the minimum of a year. The men that you have reported on and given a very poor record, we have said, "Yes, we will leave him until the end of the year, except for certain reasons where a man should come out now."

COLONEL ROBINSON:

There is no scientific method of determining whether a man has the qualifications to go into the Residency program. We have been exploring that field of having some way of determining whether a man is residency caliber with the number of universities who have reserve projects, and it is entirely possible that we may set up something so that later we will be able to select our residents and thus avoid that, but now there is nothing we have on it. Does anybody think that is worthwhile to undertake?

GENERAL STREIT:

I think it is very important because we are getting a certain number of people into this residency training program who are just average men and will never make the type of qualified men that we want. They don't have the enthusiasm for the specialty they have chosen or the aptitude or ability to carry on. Some of the universities have proposed a personal interview and I was wondering whether it would be worthwhile for The Surgeon General or one of his team to interview these applicants?

COLONEL DUKE:

I think this will take care of that. Before too long, not all of our residents but a great majority will come from our Army interns, Then each hospital will have had one full year to evaluate that man as an intern before he goes into residency and you and your Educational Committee will be able to tell us the one. It is very difficult, out of all the men who

graduate in the Medical Corps schools, to say which ones should go into residency training.

COLONEL GREEN:

I think the real trouble is getting an honest evaluation from the Educational Committee.

COLONEL DUKE:

Thank you. It is true that many of the reports look just alike.

GENERAL BEACH:

But we don't use that numerical evaluation now.

COLONEL GREEN:

We are doing the same thing by not being honest. As it should be given, he has failed - there is no question about that.

GENERAL BEACH:

I don't think there is any question at Walter Reed. The Consultant makes the evaluation; the Chief of Service and the Chiefs of Sections talk it over. They are interviewed very critically.

COLONEL DUKE:

Don't depend too much on the Chief of Service; surely he is the principal one but encourage the Educational Committee insofar as possible to get acquainted with every one of them at social affairs or staff conferences, etc., so that he has his own decision. It is an Educational Committee opinion that we want.

GENERAL BEACH:

There is one other thing that helps in the evaluation and that is to have a Director of Professional Training. He handles all the interns, he handles all the residents; he sees them every day. It is his duty to keep in touch with them; he knows what they are doing in the conferences, etc. He is comparable to the Dean of a graduate program in the large medical centers or universities and You have to have somebody riding herd in addi-

tion to Chiefs of Services and Chiefs of Sections.

COLONEL DUKE:

We wanted to have a Director of Training in every one of these 5 hospitals. I realize we are short and until we get this over this shortage executive officers will have to do it.

GENERAL FEACH:

Then who will do the Executive Officer's job? This officer's job is a full time job?

COLONEL DUKE:

I have been trying to convince Colonel Robinson of this for some time.

COLONEL HARTFORD:

We want to convene promptly at 1:30 this afternoon. We are going to have a rather informal meeting.

MEETING ADJOURNED AT 12:20 p.m.

Afternoon Session -
5 August 1948

COLONEL ROBINSON:

This is just a working session - not for the record. When you have something that you want included in the record, say "for the record", and we will pause there and put whatever it is in the record. Colonel BRAMLITT has some remarks at this time which will be a part of the record.

COLONEL BRAMLITT:

After Colonel Robinson made the statement that we would try to procure some doctors, we had to find out where we could get them. We had to have some sort of criteria as to what we would leave in the hospitals where we would obtain the doctors. On the basis of that, we started out with a plan where we would authorize the hospitals 16 basic officers - for General Hospitals, and then on top of that, we would authorize one medical officer for 50 beds. That was calculated using authorized beds. We figured that out and saw that that was going to be a little heavy, so we worked it out on the actual beds which, at the present time, there isn't too much difference, and we came to 2 different figures. Now we hope to eventually get down to where we will be in between these two figures all the time. The known teaching hospitals we determined are operating at the present time, or before this last cut, with approximately that number of people; I am referring to Medical Corps officers entirely.

The officers that we believed should be in the hospitals and there is some difference of opinion on this, was as follows:

The Commanding General,
The Commanding Officer,
The Executive Officer,
The Chief of Surgical Service,
The Chief of General Surgery,
A Chief of Orthopedic Surgery,
Chief of Ear, Nose and Throat Service,
Chief of Urology, and an
Anesthetist.

You notice we left off OB and GCN and that is one of the specialties that we may have to compromise on. We left it out because some hospital carry him on the out-patient service and others carry him on the surgical service. But by giving one doctor to 50 authorized beds we thought perhaps that would take care of the service. The medical service consisted of Chief, Medical Service. An Assistant as Chief of General Medical Service. Another Assistant as Chief of Communicable disease Section, and another Assistant in the Pediatrics service. The others that we enumerated in this 16 were Chief of NP Service; Chief of X-ray Service; Chief of Laboratory and the Chief of Physical Medicine.

For our large centers we considered one additional medical officer. In making this study we had to come to some determination as to how a resident and an intern could count. That is Senior Resident and Assistant Resident and intern. There are many ways of counting these; a full man, for the Senior Resident, an Assistant resident as three-quarters of a man, right on down the line to intern who counts nothing. On the over-all, we thought that a man in teaching should count something and as an over-all average, we settled on 50 per cent for each officer in training. We know that is open to argument. It is just a planning figure and we would like to have suggestions on that.

On this register - (indicates sheet) - that is in each folder, is a summary of what would be left after the personnel that are shown on the small roster - (indicates small sheet) - were removed. Now, the non-teaching hospitals that were not affected would not have the small roster since it is not contemplated thinning them out. In the upper left-hand corner of the roster of the Hospital you will find the calculations for the specific hospitals using the plan as outlined 16 basic officers plus one officer for 50 beds. It shows how many medical officers we figured for that hospital. That is an ideal figure and as time goes along and we loose 2,100 doctors next June unless we can talk these 2,100 doctors into staying in, we don't know whether we can reach this figure or not. We have shown in the roster under the various services a breakdown of personnel as close to the system that we had here, and the various Chiefs and Assistants as you have them today. These names were taken off the roster as of the 30th of June. Since that time, various changes have taken place; men have come out and others have gone in, but on an over-all basis - and we wanted to show you specific names - I think it comes pretty close to being what we have here in numbers. We know that people were enroute and we have assigned some ASTPs at the present time that are not shown and we didn't intend for them to be shown. Men are getting out this September, October, November who are not this list and YOU can keep them gratis and they will be there to help you until the time they are separated. Now, any man that we can talk into staying in the Army is that much more help to that specific hospital. We also have people on this list who are going out. If you have some that we have checked to be reassigned that have been promised that they would stay in the hospital for another year if they signed up for that year, then those men we will scratch from the list.

In Colonel Robinson's plan. We have to have approximately 100 doctors to make this expansion work and Colonel Robinson and myself will be glad to discuss the release of officers from the individual hospitals a little later.

COLONEL ROBINSON:

I want you all to work with this as a tentative measure. We are going to get doctors; there isn't any question about it - how, I don't know, but it will be next spring before we get them. Either that or the expansion has to fold up; it is one of two things that has to be done. So,

I would like for you all, in working with this, to realize that what it is - it is a method to keep the Armies and Air Forces from absolutely having to fold up as far as medical service is concerned and, at the same time, leaving the General Hospitals running along smoothly and quietly and that, of course, is something none of us could face before the Nation. In other words, we are going to have to spread what we have thinner to do our job until we get the relief.

I would just like to add, for the record, that the Training Program is going on in the five Teaching Hospitals. Also the Basic Science Course will be given in January - starting January.

COLONEL DUKE:

Have these been deleted from this list?

COLONEL ROBINSON:

Which?

COLONEL DUKE:

The Director of that Course and the 10 or 12 men assigned to it?

COLONEL ROBINSON:

I doubt very much that they have.

COLONEL DUKE:

Well, you can't pull them out and conduct the course too.

COLONEL ROBINSON:

Well, we will have to take some of them; we will take about 10 and leave 7.

COLONEL BRAMLITT:

86 per cent of the people on the rosters that we will take out are Company Grade Officers and I don't see how they can be involved in a teaching program. Actually, they are taking up teaching material that should be taken up by internes or residents.

(AN OFF-THE-RECORD INFORMAL DISCUSSION FOLLOWED).